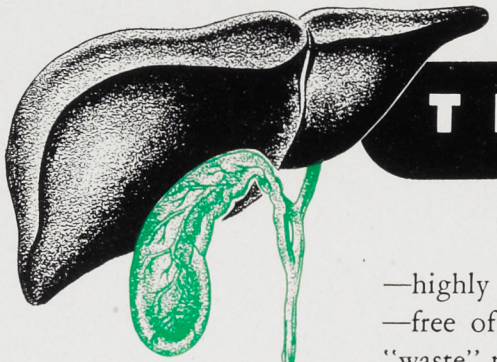
Manitoba Medical Review

Vol. 33 JUNE-JULY, 1953 No. 6

Specific Bile Acid Therapy



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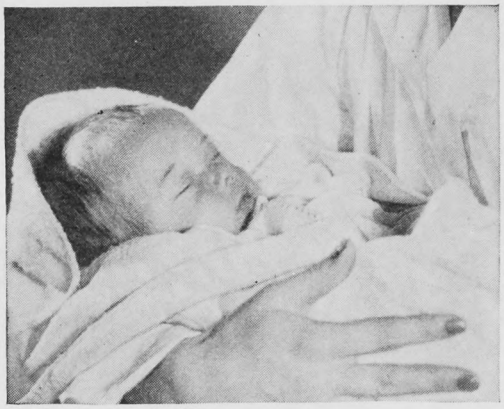
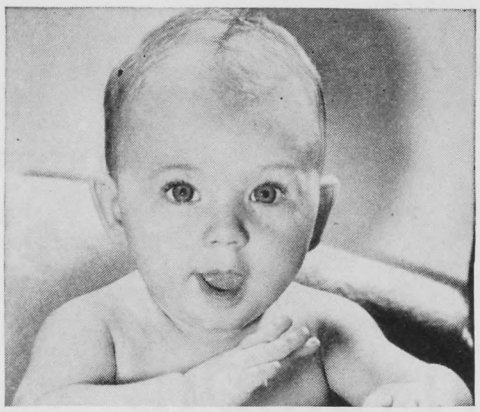
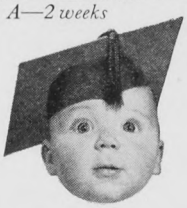


Baby A—2 weeks



Baby B—5½ months



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At Six Weeks: Increasing protein intake 25% by the addition of Swift's Meats for Babies to formula promoted hemoglobin and red blood cell formation: *Leverton and Clark, "Meat in the Diet of Young Infants," J. Am. Med. Assn., 134,* 1215, (1947).

With Allergy Cases: A formula of Swift's Meats for Babies enriched with minerals, fat, and carbohydrate offers an effective milk substitute for infants allergic to milk proteins: *McQuarrie and Ziegler, "Nutritive Value of Mineral-Enriched Meat and Milk," Pediatrics, 5,* 210, (1950).

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Natural oestrogenic conjugates (equine).

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Full-Strength
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Coloured Pink

Each tablet contains:
Questrin, equivalent to the activity of
Sodium oestrone sulphate..... 1.25 mg.
plus
Brewer's yeast concentrate..... 100 mg.
Thiamine hydrochloride..... 3 mg.
Riboflavin..... 2 mg.
Niacinamide..... 10 mg.
Pyridoxine hydrochloride..... 1 mg.
Calcium d-pantothenate..... 5 mg.
Ascorbic acid..... 25 mg.
Vitamin D..... 500 Int. Units

"QUESTRIN" COMPOUND
Half-Strength
Tablet No. 429 "Frosst"
Coloured Orange

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plus
the same factors listed under Tablet No. 430

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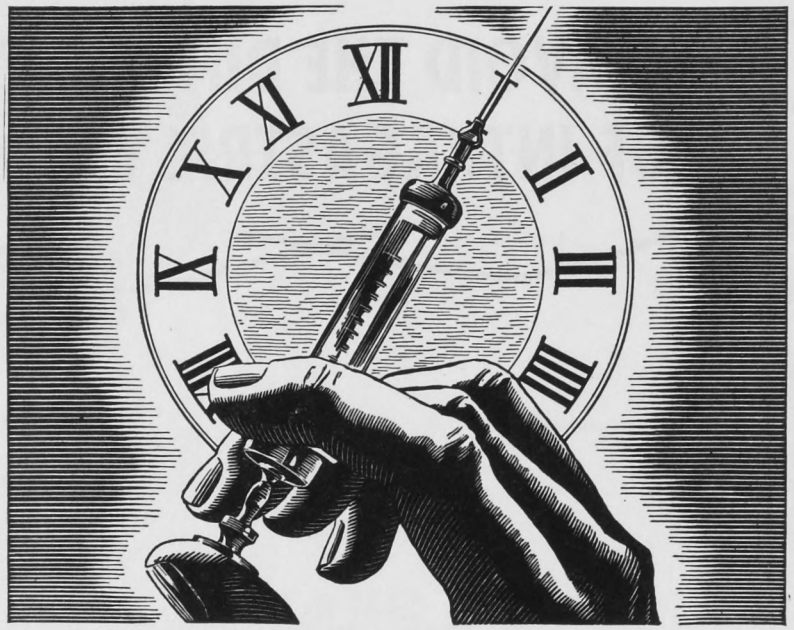

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The Manitoba Medical Review

Vol. 33 JUNE-JULY, 1953 No. 6

Obstetrics and Gynaecology

Endometriosis

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Chairman, Department of Obstetrics and Gynaecology, University of Manitoba

Endometriosis, or the presence of functioning endometrial tissue remote from the uterine cavity, has become a relatively common gynaecological diagnosis. The incidence of the condition as reported from different centres shows wide variation. Tyrone and Weed[5] reporting from the Ochsner Clinic give an incidence of 1.8%, while Meigs of Boston[2] reports an incidence of 30%, histologically proven cases comprising both series. In considering such extremes of incidence the social status of the patients probably plays a part as well as the difficulty of diagnosing the condition. Between these quoted figures lies the average incidence of approximately 8%.

Controversy exists as to the method by which the aberrant endometrium arrives at the site of implantation. Four concepts are current, the oldest being that of Sampson who postulated the transtubal regurgitation of particles of endometrium shed with menstruation. This theory accounts logically for the high incidence of endometriosis of the recto-vaginal septum, that being the most dependent part of the pelvis, but fails to explain the infiltration of the myometrium giving rise to adenomyosis or endometriosis interna. Meyer's theory of coelomic metaplasia is staunchly championed by Novak[3] although it does not account for adenomyosis nor the rare but apparently authentic cases of endometriosis of the upper and lower extremities which Novak mentions. Halban's theory of lymphatic dissemination has now been enlarged by the research studies of Javert[1] which demonstrate a benign metastatic phenomenon analogous to the spread of adenocarcinoma of the endometrium. This latest concept satisfactorily embraces infiltration, lymphatic and blood stream dissemination and surface transportation as in transtubal regurgitation, and also suffices to account for rare and far removed implants. However, it is unlikely that the theory of benign metastasis is the final word on the histogenesis of endometriosis.

Once the endometrial cells are implanted in an ectopic site the nidus mirrors the parent tissue in cyclic menstrual changes. Monthly shedding and bleeding occur resulting in engorgement of the originally microscopic implant with blood and debris and a continual increase in size. During pregnancy the lesion is quiescent and decidual reaction has been observed. At the menopause when the parent tissue has reached unresponsive senility the endometriotic lesions also become inactive and gradual involution ensues.

The causes of endometriosis are obscure. Setting aside Meyer's theory for the moment, it appears reasonable to suppose that any obstruction to the facile outflow of menstrual debris through the cervical canal might cause its dissemination in other directions. Judging from the numerous reports appearing in the literature endometriosis is increasing in certain localities and among certain social classes. Thus it is suggested that occlusive pessaries used for contraception, intravaginal menstrual tampons, and the acceptance of the congenitally retroverted uterus as a normal organ for reproductive function are factors in the apparent increase. If Meyer's theory is not to be entirely discarded, it might be asked what factor in our modern mode of living is causing increased metaplasia of the coelomic peritoneum? Meigs, speaking at the British Congress of Obstetrics and Gynaecology in 1949, made an earnest plea for fathers to subsidize their marriageable sons and daughters that they might marry young and have large families, thus serving the double purpose of increasing the birth rate among the economically favoured class and decreasing the incidence of endometriosis and its resultant infertility. The periodic resting of the endometrium by repeated gestations is stated to be a deterrent to endometriosis, yet the condition is not reported to be more prevalent in spinsters.

However speculative the aetiological factors of this condition are, the pathology is very definitely established. Where the specks of endometrial tissue become implanted fibrous tissue forms around them causing puckering and scarring. As the months go by menstrual cycles cause distension of the lesions and symptoms arise from both the implants and fibrotic changes in the surrounding tissues. In the pelvis this process may involve the rectum or sigmoid and symptoms referrable to the lower bowel may cause a patient who has put up with dysmenorrhea for many years to seek medical aid because the dyschezia with the periods has become unbearable. In a severe case of this type rectal findings may suggest a malignant neoplasm. In a pelvic appendix distortion of the organ and the adjacent structures by endometriotic lesions may produce symptoms simulating acute

*Presented at the Sectional Meeting, American College of Surgeons, Calgary, Alta., April 24th, 1953.

appendicitis. Rupture of a cystic implant with spill into the peritoneal cavity causes the acute pain of any intra-abdominal catastrophe. Thus secondary changes mask the original pathological condition.

Endometriosis of the ovary which gives rise to the tender adherent "chocolate cyst" and menstrual irregularities may cause confusion of diagnosis with an ectopic pregnancy. The rarer sites of endometrial implants as in the umbilicus, abdominal scars, the groin, the vagina and the vulva usually manifest themselves to the patient as soon as they attain macroscopic size. The complete textbook pathological findings of tender, fixed adnexa flanking an adherent retroverted uterus which rests on pebbly utero-sacral ligaments beneath a puckered vaginal vault are not often encountered. It is more likely that on performing laparotomy for fibroids, ovarian neoplasm or an abdominal emergency, distorted pelvic organs densely adherent to large and small bowel will be found. The surfaces of the organs appear sprinkled with scars centred by the tarry blebs that are pathognomonic of endometriosis. In a case such as this, where the diagnosis is obvious to the naked eye, it is disappointing to have the pathologist's report make no mention of endometriosis. The reason for this apparent discrepancy in diagnosis is that tissues shrivel and change once they become avascular and later are fixed in formalin. Also, pressure within the endometrial implants will cause destruction of the characteristic cells. If possible a pathologist should view the lesions before extirpation is commenced and give advice as to which areas should be designated for special attention in order that histological confirmation of the diagnosis may be obtained.

The chief symptom of endometriosis is pelvic pain. In the majority of cases the pain is associated with the menses, growing worse during the days of the flow and increasing in severity as the patient grows older. These two characteristics differentiate the pain of endometriosis from that of ordinary dysmenorrhea in which the pain lessens with the full establishment of bleeding, and decreases as the patient matures. In advanced cases the patient may complain of a constant feeling of heaviness in the pelvis which is aggravated with the menses and which causes definite bladder and rectal discomfort. If marked endometriotic infiltration of the rectal wall is present, with involvement of the mucosa and protrusion into the lumen, rectal pain, bleeding and passage of mucous may occur with the periods.

Irregular uterine bleeding and marked prolongation of the menses are symptoms of endometriosis interna. The infiltration of the myometrium causes congestion of the organ and increased bleeding. It is probable also that areas of adenomyosis have channels communicating with the uterine cavity. The tracts may become obliterated during the menstrual hyperemia and regain patency when the congestion has subsided. Discharge of accumulated blood from these areas will reinstitute uterine bleeding after normal endometrial proliferation has commenced in the cavity. Endometrial cysts of the ovaries will cause an upset in the normal ovarian cycle which is reflected in the endometrium giving rise to irregular bleeding. Pelvic congestion due to endometriotic masses and adhesions tends to cause a lush, vascular endometrium which bleeds on the slightest stimulus of over-exertion or excitement.

Dyspareunia is a frequent complaint if the uterus is fixed in the cul de sac or if lesions are present in the utero-sacral ligaments or in the posterior fornix. It is also present in an excruciating form if one or the other ovary is enlarged, prolapsed and fixed by generalized adhesions or by the presence of an endometrial cyst. Occasionally on examination this pain is reproduced with startling effect.

Sterility will result if the tubes are blocked or distorted by endometriotic lesions. Frequently the tubes are found to be patent, therefore some other unknown factor must underlie the infertility. However it is seldom that infertility is the major complaint of a woman with this disease. Although she may come to the doctor because of lack of progeny, the concomitant symptoms of severe and increasing dysmenorrhea come to light within the first few minutes of history taking.

The diagnosis of endometriosis is not always easy. It is necessary to keep it constantly in mind when dealing with pelvic symptoms and findings that do not fit readily into any category. The typical case with a retroverted adherent uterus, fixity of the posterior vaginal vault and tender adnexal thickenings presents no problem, especially if a rectal examination is done. It is the minimal case in which adhesions from the pathological dissemination of the endometrium are just beginning to form which presents problems in diagnosis. In any case of pelvic pain, whether associated with the menses or not, accompanied by tenderness of the internal reproductive structures in an afebrile patient, the possibility of endometriosis must be entertained along with the more common diagnoses of chronic inflammatory disease or ectopic pregnancy. In some centres endometriosis appears to have increased to the point where it is a frequent diagnosis; in others it still remains an unusual finding. This variation in incidence suggests that one will find what one is looking for.

The treatment of endometriosis should be as conservative as is compatible with relief of symptoms.

It is an affliction of women in the childbearing years and frequently manifests itself before pregnancies have occurred. If a patient who plans to have a family later on is suspected of having early endometriosis, she should be urged to try to become pregnant without further delay. Should her uterus be of the small congenitally retroverted type with a tiny external os which suggests inadequate drainage of the menstrual debris, dilatation of the cervical canal will aid drainage and may also be a factor in promoting a pregnancy. Perhaps ventral suspension is indicated in these cases, although the anatomical arrangement of the structures suggests that the normal position of that particular uterus is the retroverted one which has been assumed. If conception does not occur within a period of four to six months in this type of case, the pelvic picture may be improved by the judicious use of androgens, insufficient in amount to cause masculinizing signs or suppression of ovulation. The dose should at no time exceed 200 mg. per month of orally administered androgenic substance. This hormonal therapy may also be successful in a patient who has had one pregnancy but fails to achieve another because of developing endometriosis. If pregnancy occurs, palpable endometriotic lesions will be found to soften, regress, and perhaps disappear not to recur. Authorities differ widely on the subject of recurrence of endometriosis following pregnancy and it must be assumed that the abeyance of endometrial function during gestation does not necessarily mean complete cure of the pathological condition.

In women approaching the menopause, androgenic substances may be used to ameliorate the symptoms until such time as the ovaries cease to function and the endometrium becomes inactive. In cases of this type however the androgens must be used with great caution because the endogenous oestrogens are no longer present to help counteract virilizing effects of the therapy.

In the woman in her twenties or thirties with severe symptoms, surgical treatment is indicated. Operation on these patients is very often difficult due to the adhesions which surround the implants and the involvement of bowel or bladder in a dense fibrotic mass. As much ovarian tissue as possible should be conserved to prevent castration and to give the patient every possible chance for future pregnancies. If a retroverted uterus is present suspension is advisable, providing peritonealization of raw areas deep in the pelvis is possible to sufficient extent to preclude later bowel obstruction from new adhesions. Approximately 40% of women who undergo conservative surgical treatment will later achieve pregnancy which is a cogent argument against too radical ablation of the reproductive organs. Hysterectomy relieves the symptoms when childbearing is no longer a factor. Presacral neurectomy for relief of intractable pain varies in effectiveness .

If pelvic clean-out and complete castration is essential to relieve the condition, the gross climacteric symptoms which occur in the younger age group are best treated with androgens or a combination of androgens and oestrogens. The administration of oestrogens alone to these patients over prolonged periods of time may cause continued activity of implants in bowel or bladder with a perpetuation of pelvic symptoms. The possible carcinogenic properties of exogenous oestrogens administered for long periods must also be kept in mind.

Irradiation treatment has the same effect as surgical castration. It probably has a use in women who are approaching the menopause although the sudden cessation of ovarian activity will aggravate the climacteric symptoms and hormone therapy for their relief may be necessary. Irradiation therapy has no place in the treatment of the younger age group.

The purpose of this paper has been to present the subject of endometriosis from the clinical point of view. The condition must be kept constantly in mind when dealing with women of childbearing age who complain of pelvic pain, irregular bleeding, or relative infertility and in whom pelvic examination reveals equivocal findings.

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Survey of Caesarean Sections

St. Boniface Hospital, 1933 to 1952 (Inclusively)

H. Guyot, M.D.
Chairman of Department of Obstetrics

Once every five years I have presented at a luncheon some statistics on caesarean sections performed in St. Boniface Hospital so that now we have some fairly accurate figures and information on 354 sections done during the last 20 years and, for purposes of comparison, divided in 5 year periods.

Dr. R. Willows and Dr. G. Hardy have volunteered to review all these charts and I would like to thank them personally for their interest and for the time spent in obtaining these statistics. Anyone who has done this type of survey before will realize the amount of work it entails. The information had to be obtained from the operation sheet, temperature chart, nurses' notes, baby's chart, X-ray, etc.

Five years ago we began using a special form for caesarean sections to be completed by the

surgeon or dictated by him to the interne assisting at the operation but only 89 were filled and some were far from complete. If these forms were filled completely it would make a survey of this kind much easier and more interesting. There are still some surgeons who simply write C.S. on the operative sheet without stating what type of operation was done and without giving clearly the indications for the operation. However there is some improvement over the previous 5 years.

I believe that a survey of this kind should be made at least every 5 years to compare our results with those of the previous years and with results of other hospitals. It is our duty to look back on our work, to study our mistakes and try to improve our results.

Years	Total Deliveries	C.S.	Incidence	Post-Caesarean	Maternal Deaths
1933-37	5246	33	.63%	2	6%
1938-42	7241	75	1.03%	2	2.7%
1943-47	10406	103	.99%	1	.97%
1948-52	10989	143	1.3%	0	0

Maternal Deaths Following Vaginal Deliveries

1933-37	6	1.2 per 1000
1938-42	14	1.95 per 1000
1943-47	14	1.36 per 1000
1948-52	9	.83 per 1000

Caesarean Sections

	1938-1942	1943-1947	1948-1952
Number	75	103	143
Parity—			
Primipara	31	50	46
Multipara	38	50	96
Not stated	6	3	1
X-Rays taken	20	47	65
Type of Operation—			
Classical	61	88	91
Low	13	14	48
Extraperitoneal	0	0	2
Hysterectomy	1	1	2
Anaesthesia—			
General	72	85	67
Spinal	1	14	72
Local	2	4	4
Post-operative Days—			
(Average)	15.3	13.5	9.7
Morbidity—(Temp. 100.4 on 2 successive days)	28%	30%	17%
Number of Babies	77	104	145
Foetal Mortality (Still-births and neonatal)	14.3%	9.6%	11.7%
Maternal Mortality	2.7%	.97%	0

Indications

For 143 Sections — 1948-1952

Disproportion	42
With 1 previous C.S.	16
With 2 previous C.S.	6
With 3 previous C.S.	1
With 4 previous C.S.	1
Breech (Young primipara—under 35 yrs.)	4
Breech (Old primipara—over 35 yrs.)	3
Breech—Multipara	2
Brow	3
Face	1
With toxaemia	2
After failed forceps	4
Ruptured Uterus	4
Obstruction due to large fibroid	1
Obstruction due to pelvic abscess	1
Stenosed cervix (following conization) and breech	1
Old primipara (age 42 and 45)	2
Old primipara with fibroids	1
Pulmonary T.B.	3
Primipara with diabetes, toxaemia, T.B. and brow	1
Haemangioma of vaginal wall	1
Cerebral haemangioma (operated during pregnancy)	1
Previous repair of vesico-vaginal fistula	1
Prolapsed cord (Baby lived)	1
Diverticulum of uterus (1 previous section)	1
Placenta praevia	29
With breech and prolapsed cord	1
With twins	1
With transverse lie	1
Abruptio placenta	7

Incidence

You will notice that the incidence of caesarean sections has increased from .63% in 1937 to 1.3% in 1952. This is quite within normal limits and it could easily go up to 2% or 3%. The maximum, as set by the American Hospital Association, is 4%.

So our incidence may be considered low and some pediatricians have expressed the opinion that it is too low or, in other words, that we could save more babies by doing more caesarean sections. In a general hospital where over 100 physicians practice obstetrics there are undoubtedly some cases where the baby is lost or crippled for life due to a difficult or mis-managed delivery and where a section would have saved the baby. But we should remember that a section does not guarantee a living, healthy child even under ideal conditions. The foetal mortality following caesarean sections is still 2 or 3 times higher than for vaginal deliveries, even in the best organized and equipped maternity hospitals. This fact must be kept in mind when a section is decided upon for purely foetal indications.

Maternal Deaths

Here we have a marked reduction from 6% in 1937 to none for the last five years. We should be proud of this result but it should not make us feel too over-confident.

We must remember that delivery by caesarean section is still more dangerous for the mother than vaginal delivery and that it is not always the

simplest way out of an obstetrical difficulty. When this operation is done in modern maternity hospitals by skilled operators the mortality still runs around .5% and the maternal mortality for vaginal deliveries is less than 1 per 1,000.

Parity

There were 46 sections done on primiparas—or roughly one-third. It should be considered a serious decision to make when we elect to do a section on a young primipara. It usually means that this patient will be submitted to another section at her next pregnancy, that the size of her family will be restricted and that her uterus may rupture during **any subsequent pregnancy or labor.** For an elderly primipara, of 35 years or more, especially after a period of infertility, a caesarean section is often indicated.

Multiparas are more subject to placenta praevia and abruptio placenta. They often have other complications of a general systemic nature such as hypertensive vascular disease. There were a few cases in this series where the attending doctor was lulled into a false sense of security because the patient had had 4 or 5 normal labors. The size of the baby is liable to increase with repeated pregnancies and is an important factor in cases of disproportion. A mother may deliver an 8 pound baby without too much difficulty but she will not deliver a 10 or 12 pound one.

X-ray

There were 65 X-rays taken for disproportion, malpresentation and placenta praevia.

An X-ray will give valuable information as to size and shape of the pelvis, position and presentation, size of foetal head, etc., but the radiologist reports only what he sees on the films. We should not rely on an X-ray report alone before we decide to do a section; the clinical findings and the progress of labor are far more important. And sometimes an X-ray is misleading.

I will give two cases to illustrate:

1.—Mrs. F. D. Primipara—Twin pregnancy—one cephalic and one breech. On the X-ray film the breech baby appeared to have a huge head, almost a hydrocephalus. A consultant agreed that a section was indicated to deliver the breech baby safely. A low section was done—unnecessarily. Both babies were quite normal, one weighing 3 lbs. 6 oz., the other 6 lbs. 8 oz. The size of the head of the larger baby, presenting as a breech, had been exaggerated on the film because it was further away from the plate.

2.—Mrs. S. K. Para vii—Age 35. History of previous difficult labors with 8 and 8½ pound babies. X-ray report: "There is ample room." Patient in labor 32 hours, with strong contractions and no engagement of the head. Lower segment tender, on the verge of rupture. A low section was done and a 12 lbs. 5½ oz. baby was delivered.

In cases of placenta praevia a vaginal examination is essential to determine the amount of praevia or covering of the os. An X-ray is of value only in cases where the placenta is clearly demonstrated in the fundus and when bleeding is due to abruptio or some other causes.

Anaesthesia

There were 72 spinal, 67 general and 3 local anaesthetics given. There is a marked change over the previous five-year period (1943-47) when only 14 spinals were given for 103 sections. At that time many obstetricians were condemning this type of anaesthesia, following De Lee's teaching. Now spinal anaesthesia seems to be the one of choice with good results provided it is given by an experienced anaesthetist and in small dosage. It allows more time for the surgeon to extract the baby, without rushing and the child is not anaesthetized. The uterus also contracts more readily after delivery. It is contra-indicated in cases of severe bleeding.

Type of Operation

There were 79 classical caesarean sections plus 12 sections which were not specified and which I suspected were all of the classical type, making a total of 91 classical sections. There were 9 cases where the incision was made high in the fundus. This should never be done because the danger of rupture in a subsequent pregnancy is greatly increased. Adhesions to the bowels and abdominal wall are also more common.

The classical operation has been obsolete for many years and should be used only where speed is an important factor for the safety of the mother and baby. The incision should be made as low as possible, immediately above the bladder and just large enough to deliver the baby. Forceps should be used to deliver the head **slowly and gently,** instead of pulling the baby out by the feet. The baby should be held immediately by its feet, head down, and the chest gently squeezed to expel amniotic fluid. There is no necessity to clamp the cord immediately. The uterus should remain in the abdomen while suturing it.

There were 48 low sections, an improvement over the last survey. This is partly due to the change in anaesthesia, from general to spinal, because it takes a little longer to deliver the baby with a low section. The advantages of a low section are well known: less danger of infection after prolonged labor or after membranes have been ruptured for a long time, less danger of rupture in a subsequent pregnancy, less bleeding at the time of operation (even in cases of placenta praevia), less post-operative adhesions.

Two extraperitoneal sections were done. This is a more difficult operation indicated for grossly infected cases. There is more danger to injure the

bladder and very often ends up in a transperitoneal section because the peritoneum is accidentally opened. Many obstetricians claim that with antibiotics the low section has no more morbidity than the extraperitoneal.

The two hysterectomies were done after rupture of the uterus.

Post-operative Days

Average 9.7 days.

Morbidity 17%

A marked improvement in these 2 figures is noted mostly due to blood transfusions, antibiotics and sulfas, early ambulation and better surgery and anaesthesia.

Foetal Mortality 11.7%

This is considered high and yet many of these sections were done to assure a live baby. Many series of caesarean sections published recently give a foetal mortality of around 6%.

In this series we can account for 11 foetal deaths which were more or less unavoidable: 8 associated with placenta praevia and 3 with abruptio. The other 6 could have been avoided: 4 ruptured uterus and 2 sections were done too late in cases of disproportion after prolonged labors.

Indications

85 caesarean sections were done for disproportion, 24 of them were repeat sections, 9 with breech presentation, 4 after failed forceps.

From the meagre information that we could get from the charts I would say that 20% of these sections were done without sufficient indications. They were so-called disproportion without a trial of labor or with a test of labor which was too short and inadequate to estimate the possibility of vaginal delivery, X-rays which were taken 2 or 3 weeks before and which were not of much value as far as disproportion was concerned, or the history of 1 or 2 previous difficult labors. The main indication in most of these cases appears to be "cold feet"—on the part of the attending doctor.

A breech presentation is not an indication for caesarean section unless there is a contracted pelvis, a large baby or in an elderly primipara of 35 to 40. A radiological sign which should be looked for in a breech presentation, and usually indicates a large baby, is a flattening of the top of the head by pressure of the fundus. In a recent case of mine in which this sign was present, in a primipara 30 years old, delivered by section, the baby weighed 9 lbs. 10 oz.

If a patient has had a previous caesarean section it does not necessarily mean that she has to be delivered by section again. These cases should be watched carefully during labor and an X-ray should be taken to determine the site of the placenta. If the placenta is situated anteriorly over the old scar then a repeat section is likely indicated because the placenta weakens the scar. It is also important to know if the previous section was a classical or a low one. The risk of rupture after a classical section is about 8 times greater than after a low section.

Four sections were done after forceps had been applied and failed. All babies survived and none of the mothers had a temperature high enough to be called morbid, i.e. 100.4 degrees on 2 successive days except for the first 24 hours. These 4 patients were saved mostly by antibiotics, transfusions and low sections. I did 3 of them on cases where I was called after failed forceps. In one case forceps had been applied several times on a floating head during the course of 2 hours.

There were 4 cases of ruptured uterus and no maternal death. Such good result could not be credited to good management but rather to sheer luck. Statistically speaking, 1 or 2 of these should have died. I will give you a brief history of each case:

1. Para i. Age 26. Had 1 previous section for breech presentation and the baby weighed 8 lbs. She was at term and no sign of toxaemia. Medical inductions were given on 3 different days with quinine and pituitrin. She ruptured after the third induction. The placenta was extruded through the old scar. A stillborn baby weighing 8 lbs. 13 oz. was delivered. The tear was repaired.

2. Para ii. Age 20. Diabetic. She had 1 vaginal delivery with a stillborn baby and a caesarean section also with a stillborn baby. She was admitted to hospital at 7 months, in diabetic coma, treated by her own doctor and sent home. She returned at term, apparently in labor and with severe acidosis. Her condition deteriorated rapidly after admission, her abdomen was distended and tender; she was exsanguinated, in shock from haemorrhage and in diabetic coma. Then she was expeditiously transferred to staff. She was in such a poor condition that operation was out of the question. Her acidosis was treated and in 18 hours, after several transfusions, we were able to risk an operation. The baby was lying in the abdomen with the placenta, the uterus had contracted firmly and had stopped bleeding. A hysterectomy was done. She was discharged 18 days later.

3. Para iii. Age 37. The patient had been in labor several hours with a transverse lie and a retraction ring. The membranes ruptured and a hand presented at the vulva. A consultant was called who attempted to bring a foot down and then realized that the uterus was ruptured when a gush of blood came. She was operated on; a stillborn baby was delivered and the laceration repaired.

4. Para ii. Age 32. At term, in labor 26 hours, fully dilated. Some internal manipulation was done under anaesthesia (not stated on report). The pains stopped, no foetal heart sounds heard; there was abdominal tenderness and shock. She was

operated on immediately, a stillborn 8 lbs. 11 oz. baby delivered and a hysterectomy done.

There were 32 cases of placenta praevia with 8 foetal deaths—a foetal mortality of 25%. Perhaps a few babies could have been saved if a section had been done earlier but in these cases the main purpose is to save the mother's life. In marginal placenta praevia, when the cervix is dilating and bleeding is not severe, simple rupture of membranes is all that is required. If the placenta covers half or more of the os a section is indicated.

There were seven cases of abruptio placenta with 3 foetal deaths. Usually in these cases the baby dies in a matter of minutes or hours. A few may be saved by immediate operation. The fear of a Couvelaire uterus requiring hysterectomy is, I believe, greatly exaggerated.

It is satisfying to note that toxaemia was never a primary indication for section in this series. Conservative treatment still gives the best results in these cases.

Obstetrical Emergencies

E. D. Hudson, M.D.

The maternal deaths in Manitoba in 1952 were 22. It is important that preparations be made in advance to handle the common emergencies.

The third stage of labor is attended by the threat of hemorrhage. It is often profuse and the patient deteriorates rapidly. Adequate exposure is a prime requisite in the control of any bleeding. A pair of vaginal retractors and sponge forceps are always included in the maternity tray to provide good visualization of the cervix.

Case History

Mrs. M. B. Age 21. Admitted Nov. 11, 1952.

Entrance Complaints: In labor for third pregnancy.

Past Illnesses: Usual childhood diseases. No operations.

Review of Systems: Essentially negative.

Menstrual History: Onset at the age of 15. Regular 28 day cycle, 5 day duration.

No Dysmenorrhea. LMP Feb. 8, 1952. Expected date Nov. 15, 1952.

Examination: A young Indian girl in apparent good health showing no great distress with each uterine contraction.

Head and Neck—Normal.

Teeth—In good repair.

Chest—Clear. X-ray normal.

Abdomen—Full Term pregnancy.

Previous Pregnancies:

First, Donna, age 3, delivered in cottage hospital after 24 hours labor. No difficulty. Second, Gloria, age 2, delivered in hospital after 12 hours of labor. No difficulty. Third, present delivery.

She was admitted at 11 a.m. having pains every twenty minutes. S.S. enema was given and a prep. was done. The pains continued without much increase in severity until four o'clock when the pains stepped up to twenty minutes and become a little more severe. Six o'clock 100 mgs. of demerol were given. Examination at this time revealed a cervix that was only slightly dilated but thinned out. At 10.15 the pains were every two minutes. Cervix was now fully dilated and the membranes ruptured. The head was well down in the pelvis in a transverse position. There was a bluish swelling extending into the vulva along the vaginal mucosa. This appeared to be a sub-mucous hemorrhage. The head was rotated manually to an occiput-anterior position and she delivered spontaneously.

As soon as the head was delivered there was a profuse hemorrhage from the vagina along the body of the fetus. The baby was delivered rapidly. This was attended by a copious flow of blood. The cervix was grasped by the sponge forceps and on examination there was a tear on the right side of the cervix involving a large branch of the uterine artery. The tear was repaired with chromic and the patient was returned to the ward in good condition although pale. Post Partum course was uneventful.

Summary: A case history of post partum hemorrhage from a torn cervical artery. The control of this hemorrhage was simplified by having adequate equipment immediately available.

Urology

Treatment of Prostatism

Dr. C. M. Spooner
Toronto Western Hospital

The application of the various operations for the surgical relief of bladder neck obstruction has been a controversial point for over a quarter of a century and even today there is considerable variation in thought on the subject in different countries, in various schools and even amongst closely associated urologists.

For years suprapubic prostatectomy was the classical operation, challenged only in popularity by the perineal approach, until the revival, modification and popularization of the transurethral research by John Chaulk of St. Louis in the late 1920's. More recently, Terence Millin of London dug up another antique and modernized the retropubic operation. At the present time there are the four operations available for the relief of prostatism. Considerable variations in technique, pre-operative care and post-operative treatment exists and influences the effectiveness of any procedure in the hands of different urological surgeons.

The object of this paper is to discuss the various types of prostatectomies and the indications for the effective use of each in the different clinical types of bladder neck obstruction.

For the purposes of this paper, bladder neck obstruction is divided into three clinical types, namely:

1. Contracture—the end result of an inflammation resulting in a general contracture or median bar formation.

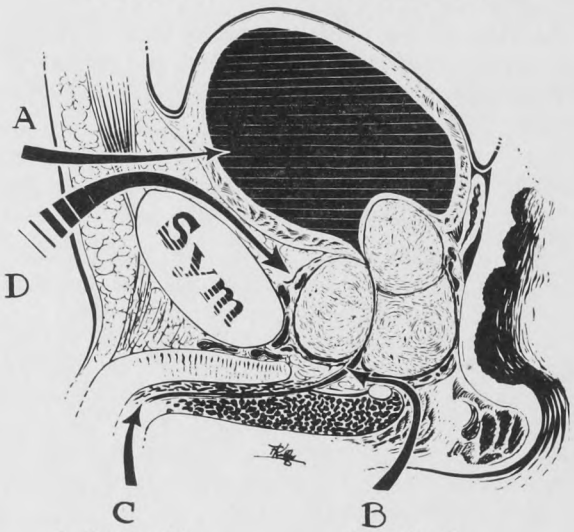
2. Benign hypertrophy or adenoma of the prostate—which produces considerable variation in the anatomical distortion and degree of enlargement of the gland.

3. Carcinoma of the prostate—neoplastic disease of the prostate can be further divided for clinical purpose into cases amenable to radical surgery and those cases in which surgery offers only palliation.

Transurethral resection is deservedly the popular operation on this continent today. It is ideal for the great majority of cases requiring surgical relief and no one will question its use in restoring normal bladder function in the various types of contracture, in the small adenoma and, lastly, as a palliative measure in relieving obstruction in late carcinoma of the prostate. In this operation a satisfactory inspection of the bladder neck is possible and is followed by a low mortality rate and a short and comfortable convalescence. Incontinence can occur but is rare.

It has obvious disadvantages. It is technically a difficult procedure and in very large glands the operation is necessarily a long one with haemorrhage and shock. Frequently there is inadequate removal of gland tissue with a return or persistence of bladder neck obstruction. The urethra is frequently traumatized by the prolonged instrumentation. When used to remove adenomata, nothing short of a complete removal of adenomatous tissue is satisfactory. This involves deep resection to the false capsule of the prostate with frequent rupture into the perivesical veins. If a haemolyzing, irrigating medium, such as water, is used, grave consequences may result from the escape of the medium into the general circulation.

Surgical Approaches to the Prostate



A. Suprapubic. **B. Perineal.**
C. Transurethral. **D. Retropubic**

In many centres the popularity of the suprapubic prostatectomy continues. A recently published monograph on prostatectomy by Charles Wells of the University of Liverpool recommends a suprapubic approach for all types of bladder neck obstruction and recommends relief of the obstruction by transvesical resection of the obstructing adenoma or fibrous tissue. His treatment would not find favour amongst many on this continent. The main advantages of the suprapubic route are; its technical simplicity, the good exposure of the bladder and the adequate removal of the hypertrophied tissue. In addition, it is probably the operation of choice when large bladder calculi are associated with benign hypertrophy. It is not commonly followed by as satisfactory a convalescence as the other operations and is not adaptable for the relief of malignant obstruction.

With specially trained and experienced urologists, the perineal operation is an amazingly simple and gratifying performance. Technically

it is simple, dependant drainage is obtained and the urethra and prostatic capsule are repaired at the time of operation. The mortality rate is low. The radical perineal prostatectomy is the most satisfactory management for the radical treatment of early carcinoma of the prostate. However, even in skilled hands, it is frequently followed by urinary incontinence. Another disadvantage is the lack of adequate exposure of the bladder interior during the operation.

Retropubic prostatectomy is the newcomer in this group of surgical procedures. Briefly, its obvious advantages are: the simple direct anatomical approach, the adequate visualized removal of tissue and the complete structural repair which can be accomplished. One of the most pleasing features is the comfortable and short post-operative confinement. Functional results are excellent. We have found it to be particularly useful in exploring the prostatic urethra in cases of poor bladder function following inadequate transurethral resection. Possible complications include haemorrhage, shock and sepsis.

The radical retropubic prostatectomy, as described by Millin, is a difficult and a not altogether satisfactory operation. Difficulty is experienced in approximating the bladder neck to the divided urethra. The radical perineal prostatectomy is preferable. An extra-urethral retropubic prostatectomy has been described by Schwartz. It is difficult to see how this modified operation would be of much use in treatment of the large adenoma. Within the past few years, prostatectomy has been advocated as an emergency measure by some British writers. Personal experience with only two cases, not included in this series, did not impress the writer as it being a sound procedure. One case died and the second had a series of unfortunate complications ranging from immediate post-operative shock to late contracture of the bladder neck. It would appear that there is advantage in a more deliberate consideration of surgery after relieving the acute obstruction by the usual methods.

The following statistics from the records of the Toronto Western Hospital are of interest. During a given period, ten hundred and seventy-four (1074) transurethral resections were done. A breakdown of this number into various types of obstruction has not been made. There were eighteen (18) deaths from this procedure. During the same period, nineteen (19) suprapubic and one hundred and seven (107) retropubic operations were performed. There were three (3) deaths in the former group and five (5) following the Millin operation. During the same period forty-three (43) deaths occurred in patients who were admitted in extremis and whose general condition never became satisfactory enough to permit surgery.

Therefore, in about ten per cent (10%) of cases requiring surgical relief of bladder neck obstruction over this period, the Millin operation was performed. The mortality rate of over four per cent (4%) as compared to less than two per cent (2%) in the cases resected transurethrally is not unexpected as there is an almost negligible mortality following resection of contractures and carcinoma for palliation. It is worthy of comment that the only basis of selection of cases for retropubic prostatectomy was the estimated size of the adenomatous obstruction. Further, it is noteworthy that the mortality rate decreased as technique improved with experience.

Summary

It is obvious that the indicated treatment of any type of bladder neck obstruction is an individual problem. Contracture of the bladder neck and late carcinoma are dealt with by transurethral resection. The great majority of cases of benign hypertrophy are satisfactorily resected by endoscopic methods. It is with the gland weighing more than forty (40) to sixty (60) grams that difference of opinion exists as to the most suitable surgical treatment. Our personal preference is to deal with these glands by the retropubic operation. Haemorrhage and shock have not been excessive and with improvements in technique, the operation has become relatively simple. The gratifying convalescence has already been commented on.

The suprapubic approach is still indicated in large glands complicated by a diverticulum or stone and it is probable that the radical perineal operation is, at the present time, the therapeutic answer to complete eradication of early carcinoma of the prostate.

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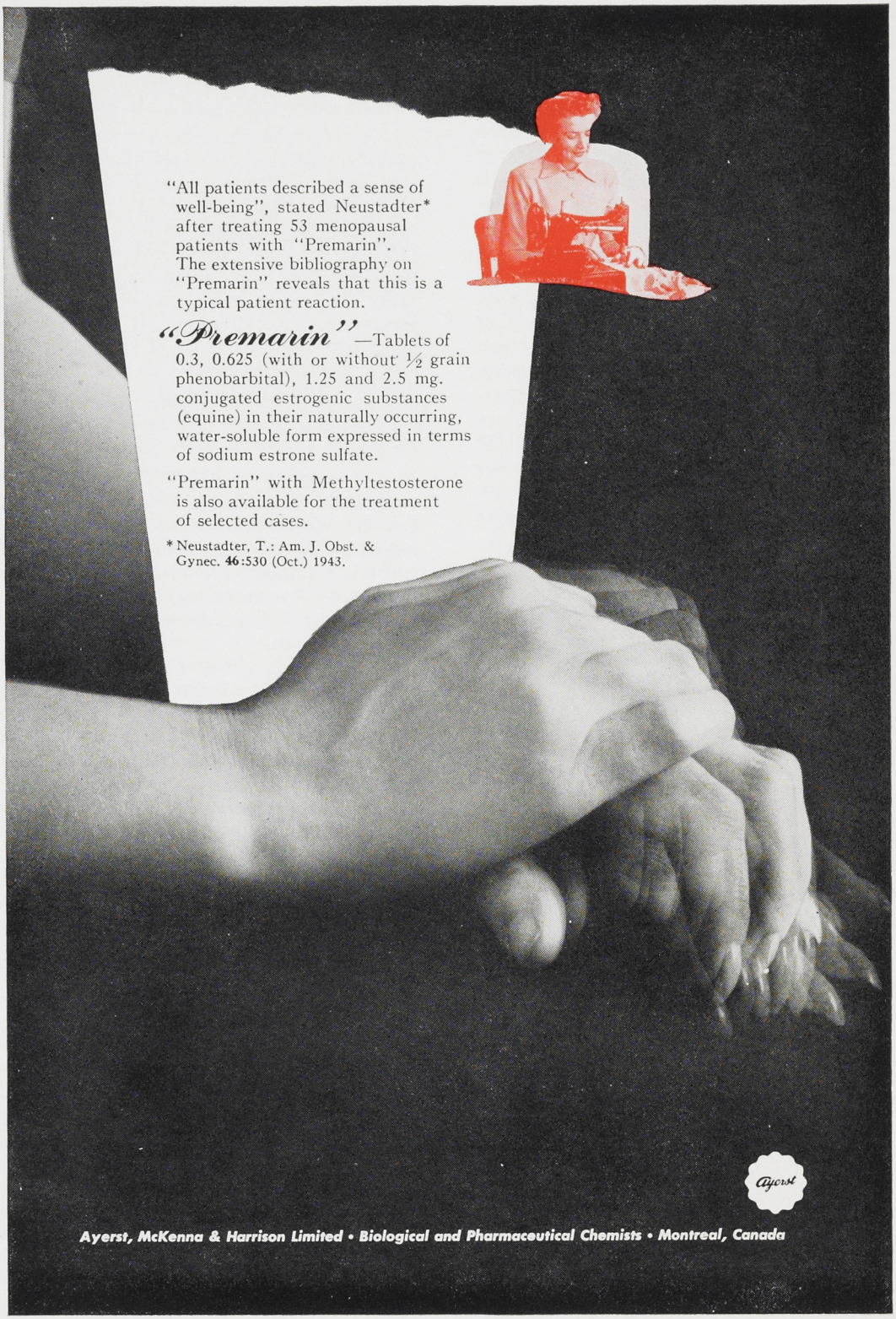
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* Neustadter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.
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Tuberculosis

Recent Advancements in the Treatment of Tuberculosis

A. H. Povah, M.D.

Medical Superintendent, Brandon Sanatorium

The new anti-tuberculosis drugs and the improvements in surgical techniques and in anaesthesia have changed the outlook for the tuberculous patient considerably. Streptomycin, discovered by Waksman and his associates in 1944, was probably the greatest advancement in treatment in recent years. By the use of smaller doses, such as one gram every third day or twice a week, combined with Para Amino Salicylic Acid, grams 12 per day, Streptomycin can be given for long periods of six, eight, twelve months, or longer without fear of the patient's tubercle bacilli becoming resistant to the Streptomycin.

I would like to show you a few cases favourably influenced by the use of these drugs.

A case of Lupus Verrucosa (Fig. 1) in a male aged seventeen. The condition had been present twelve years, dating from the time when an abscess broke and matter ran down the patient's leg. The diagnosis was confirmed by biopsy and is a Tuberculous Skin Lesion, which occurs where the part comes in contact with infected material. The condition healed following administration of sixty grams of Streptomycin.

The second case is a similar condition on the thumb, or a Butcher's Wart, which healed with P.A.S. and S.M.* therapy.

Scrofuloderma, similarly, usually heals quickly on S.M. and P.A.S. Occasionally, persisting sinuses, ragged skin edges, and tuberculous granulations have to be removed surgically.

Tuberculous Cervical Adenitis is treated by excision of the glands with S.M. and P.A.S. pre- and post-operatively. The condition generally heals without drainage or sinus formation, nor is it necessary to wait until the acute phase is over to operate. Before S.M., one hesitated to cut into tuberculous tissue, owing to the danger of chronically draining tuberculous sinuses.

Next (Fig. 2) is a case of a Tuberculous Testicle, proven by biopsy, likely primarily of the epididymus, in a boy 16 years of age. This patient

Presented at the Annual Meeting of the Manitoba Medical Association, Winnipeg, October 8th, 1952.

*Para Amino Salicylic Acid and Streptomycin.

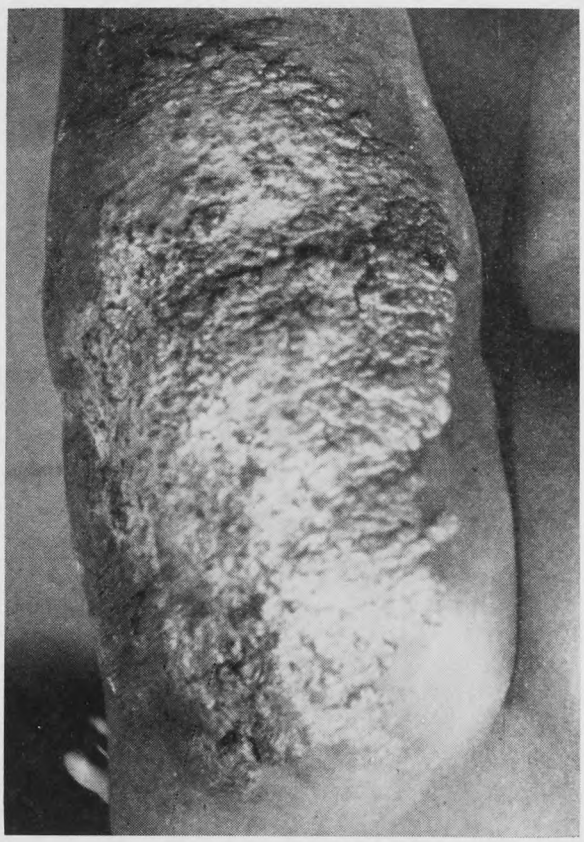


Fig. 1 — Lupus Verrucosa.

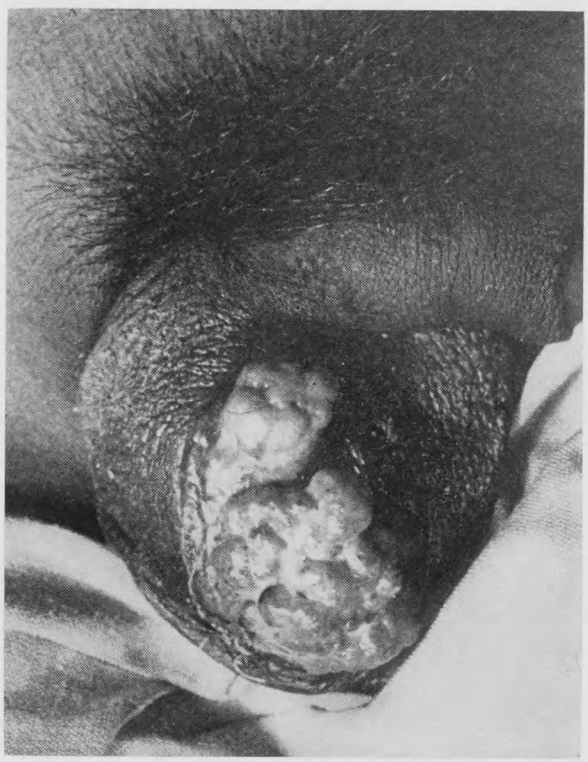


Fig. 2 — A Tuberculosis Testicle in a boy aged sixteen.

has received 84 grams of S.M. and 896 grams of P.A.S., and the condition is now healed. If the urine remains positive, he will possibly still require removal of the involved epididymus.

Gastrointestinal Tuberculosis—(Fig. 3) is a rare case of a hypertrophic or hyperplastic form of Tuberculosis of the Bowel, which generally involves the cecum and ascending colon. The lesion greatly diminishes the size of the lumen of the bowel. This patient, a male aged twenty-seven, had had an appendectomy performed three years ago and the wound healed satisfactorily. A year later, there developed redness and swelling around the scar and the area finally broke down, leaving a fecal fistula. On admission, a year later, culture of material from the fistula grew tubercle bacilli. Dr. H. S. Evans excised the fistulous tract and did a hemicolectomy and, with the aid of 52 grams of S.M. and 896 grams of P.A.S., a good result has been obtained. The patient is now discharged.

Tuberculous Pyonephrotic Kidneys can be removed under a S.M. and P.A.S. barrier without the fear of post-operative sinus formation, even though the entire length of the ureter may not be taken. S.M. will also greatly improve the symptoms of renal tuberculosis and the accompanying cystitis, and render the urine temporarily free of bacilli. It will not, however, cure renal tuberculosis, so that nephrectomy still has its place, if involvement is unilateral.

Tuberculous Meningitis—Before S.M., Tuberculous Meningitis proved to be fatal within about six weeks. Now, sixty to seventy per cent of patients recover. This patient, a female fourteen years old, was admitted in August, 1948, with miliary meningitis. Culture of her cerebrospinal fluid grew tubercle bacilli. She was discharged July 11th, 1950, with no residual effects and is working as a chambermaid. Usual dosage has been S.M., grams 1 per day for one month, then 1 gram every third day, and P.A.S. 8 grams per day, and intrathecal S.M. 100 mgm. per day for thirty days, then every second day for thirty days, then twice a week for thirty days. Most important, in successful treatment, is early diagnosis with prompt institution of chemotherapy. Of seventeen cases diagnosed since 1949, nine are alive and well, one is still on treatment, and five have been discharged from Sanatorium. Only side effects were a partial spinal block in one, which proved of no deleterious effect, and a partial temporary paralysis of the lower limbs in the one still on treatment, from which she is recovering. It has been our practice latterly to keep patients on treatment for three hundred days to one year.

Surgical treatment combined with P.A.S. and S.M. is also giving gratifying results in the treatment of Bone and Joint Tuberculosis.

The first case (Fig. 4), a girl aged sixteen, who had had a limp for five years, was admitted with a large mass of granulation tissue on her ankle posteriorly. Biopsy proved it tuberculous, and X-ray showed destruction of the talo-calcaneal joint. The granulation tissue melted away on 42 grams of S.M. Then Dr. Alexander Gibson fused the talo-calcaneal joint, removing all tuberculous

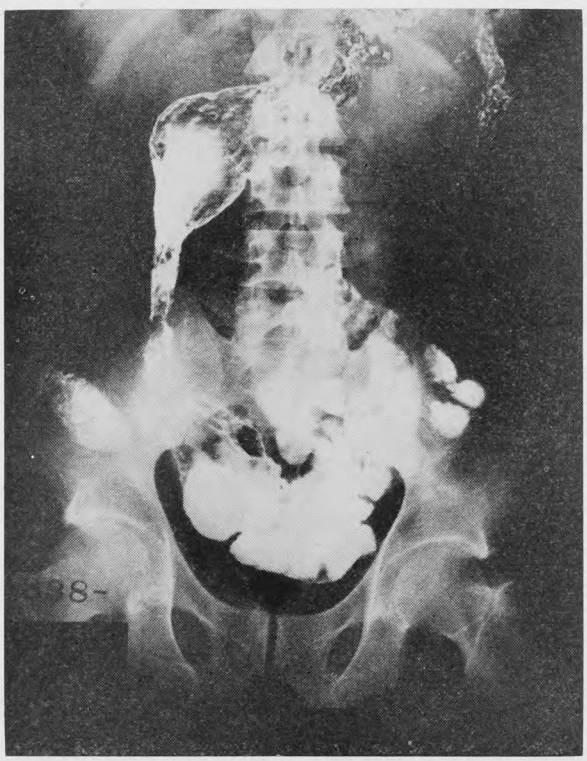


Fig. 3 — Hypertrophic or Hyperplastic Form of Tuberculosis of the Bowel (Barium Enema).

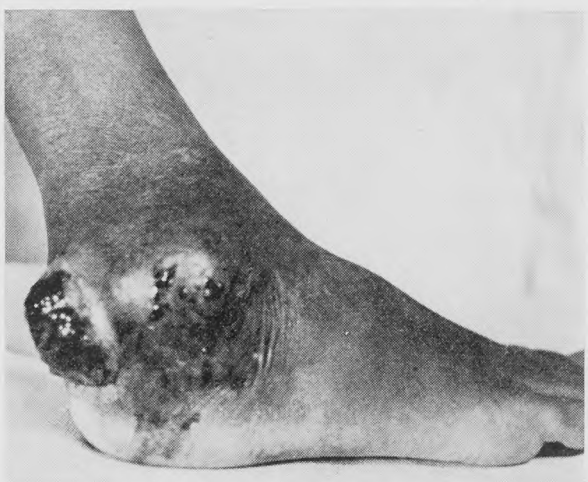


Fig. 4 — Tuberculosis Ankle.

tissue, and the part was put up in plaster. She received another 77 gms. of S.M. She was finally discharged with a functionally good limb.

The next case, a male aged twenty, a spastic paraplegic, had had paralysis of both limbs for two months prior to admission, due to tuberculous involvement of Thoracic 9 and 10 vertebrae. Spine X-rays showed complete collapse of these vertebrae and a large bilateral paravertebral abscess. The patient was nursed in plaster with the spine hyperextended and, five months later, a costotransversectomy and hemilaminectomy was done by Dr. A. Gibson to relieve the pressure on the cord. During this time, he received sixty grams of S.M. Three months later, a fishtail spinal bone graft was done by Dr. Gibson, at which time he again received S.M. 44 grams. The patient was discharged six months later with normal lower limbs except for slightly brisk ankle and knee jerks.

This Eskimo boy (Fig. 5), aged ten, from Pelley Bay on the Hudson Bay, was admitted with a marked kyphos due to complete destruction of Lumbar 2, 3 and 4 vertebrae, and was unable to stand erect. The patient was put up in plaster for fourteen months with the spine in hyperextension, so that gradually with each change of plaster, the back was made straighter. Then a spinal bone graft was done by Dr. Gibson, following which he was nursed in plaster shells for thirteen months. At the time of surgery he also received 896 grams of P.A.S. and 56 grams of S.M. He is now able to stand and walk erect, the kyphos having largely disappeared (Fig. 6).

Tuberculosis of the Greater Trochanter—Dr. Gibson has operated on six cases of this rare condition and all obtained good results, only one recurring. The involved bone is removed and any tuberculous tissue or sinus tracts excised during treatment with S.M. and P.A.S. This patient was admitted with discharging sinuses over the greater trochanter. Under the above treatment, a good result was obtained.

The next case had the base of the fifth metatarsal involved with an overlying sinus. After removal of the sequestrum and S.M. and P.A.S. therapy, the condition healed.

This patient also had sinuses on his back overlying the 9th and 11th ribs, which were involved with tuberculosis. The involved segments of rib were resected and, with P.A.S. and S.M. therapy, the wound healed without sinus formation.

The next patient was admitted with a spontaneously fused tuberculous knee but in bad functional position due to too much flexion. Dr. Gibson did a spike osteotomy, i.e., he broke down

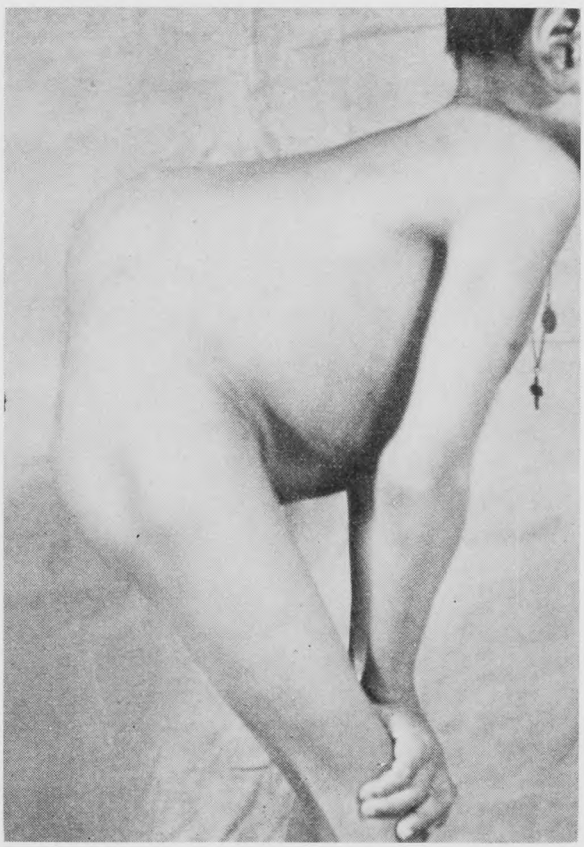


Fig. 5 — Eskimo Boy, aged ten, with Pott's Disease.

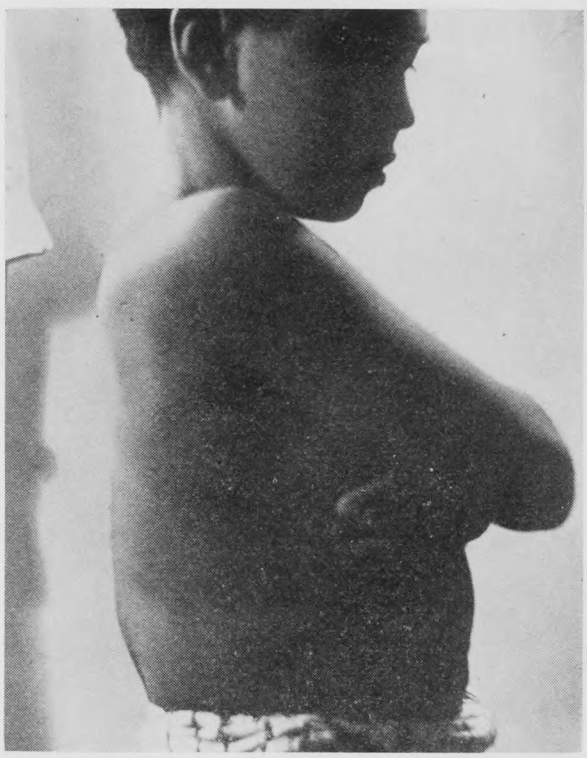


Fig. 6 — Same Case, Eskimo Boy. Final Result

the fusion and then tapered the lower end of the proximal part and fitted it into a socket created in the upper end of the distal part. With P.A.S. and S.M. therapy, the patient obtained a solidly fused knee in good position without sinus formation, though tuberculous tissue was opened into.

The next patient, a male aged 19, developed a cold abscess over the left scapula and in the left axilla, which later broke down with sinus formation. Using a curved parascapular incision, so that a pneumonectomy could be done later through the same incision, the tip of the scapula was removed and the sinus tracts excised (Fig. 7). The tuberculous process had eaten a hole about 3 cm. in diameter through the tip of the scapula. With the aid of S.M. and P.A.S., the condition healed completely and, at a later date, a left pneumonectomy was performed for total lung involvement. The patient is now well with sputum negative to smear and concentrates. Examination of his gastric contents has not been done as yet.

The admission film of a girl aged fourteen showed so much pulmonary tuberculosis, we thought she had no hope of living, but we felt we should nevertheless treat her, and placed her on S.M. and P.A.S. She received 224 days' treatment with these drugs, which included 127 grams of S.M. The disease gradually cleared out completely except for a minimal stable lesion in the right lung and her sputum became negative to gastric culture. She was discharged the other day. The above is the ideal type of pulmonary tuberculosis to treat with S.M., i.e., the acute exudative type of lesion. Chronic fibroid disease does not respond to treatment except to render the patient's sputum temporarily negative.

Isonicotinic Acid Hydrazide and its Isopropyl derivative were given premature press reports from the Sea View Hospital concerning the wonderful results produced in the treatment of tuberculosis. This created so much optimism that we felt for sure we would soon be out of work. However, these drugs have not changed the picture materially except to add to our treatment armamentarium. They are not so effective as P.A.S. and S.M. but are cheaper, less toxic, and can be used in Streptomycin-resistant cases with considerable benefit. One patient, still on treatment, was admitted with a 4.5-cm. cavity in the right lung. To date, she has received 200 mgm. of I.N.H.* daily for 112 days and the cavity is greatly reduced in size. She is slated for lobectomy.

Remarkable is the improvement in symptoms that I.N.H. produces. Temperature drops, cough and expectoration are reduced, toxic patients develop ravenous appetites and gain weight. Improvements noted in X-rays are similar to the results obtainable with P.A.S. and S.M., and bacillary counts in the sputum are reduced.

*Isonicotinic Acid Hydrazide.

Fig. 7 — Tuberculosis of the Scapula.

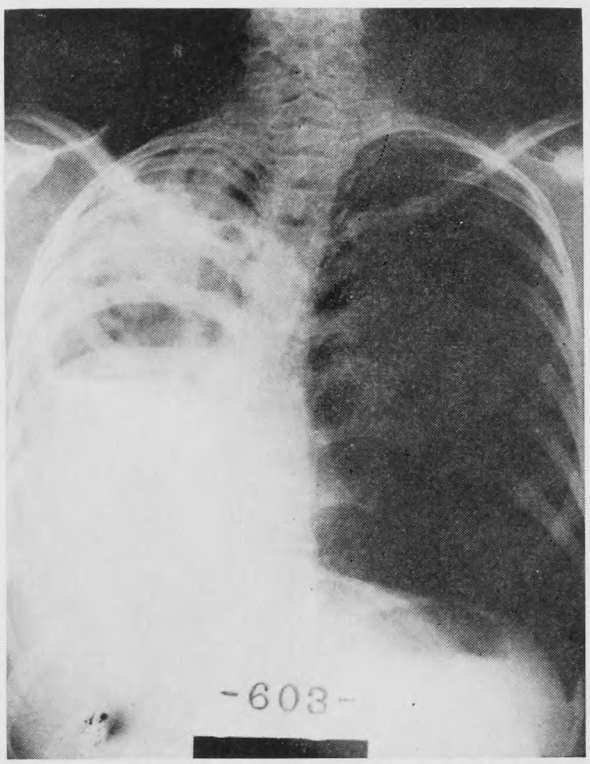


Fig. 8 — Drowned Lung with Huge Cavity Formation.

However, drugs cannot replace destroyed parts of the lung. Also, in many cases, extensive disease is reduced to small foci in the lung that continue to discharge tubercle bacilli and remain a threat to the patient's health if they should flare up again, so chemotherapy is increasing the number of patients coming to surgery, and improving the results obtainable with surgery.

We are now able to remove involved lungs, lobes, or parts of lobes of lungs, even with spillage of caseous material, with little danger of spread of infection, as was feared in the pre-Streptomycin era, especially to the pleural cavity or uninvolved parts of the lung or other lung. There is also less danger of bronchial fistulae. Improvements in anaesthesia as well as operative techniques have also made excision of pulmonary tissue feasible.

The first case, a girl aged eighteen years, was admitted with a history of cough and yellow sputum, oz. 2 to 3 per day, for three years. Sputum was positive for tubercle bacilli and chest film disclosed a right basal cavity. Bronchograms demonstrated advanced bronchiectasis in this region. Some time later, blockage of sputum occurred due to bronchial obstruction and the patient developed a drowned lung with huge cavity formation at the base (Fig. 8). The condition failed to respond to chemotherapy and repeated bronchoscopic aspirations, so a right pneumonectomy (Fig. 9) was performed three months later, and then thoracoplasty to close the empty space created. The patient received 896 grams of P.A.S. and 78 grams of S.M. pre- and post-operatively. She raises no sputum now. (Fig. 10) Gastric culture failed to grow tubercle bacilli.

A boy aged sixteen years developed a condition eight years ago, thought to be a lung abscess. Open drainage was done only to find that sputum was positive, and he has been in Sanatorium since with a broncho-pleural cutaneous fistula (Fig. 11), from which he would frequently haemorrhage and which required daily dressings. While in Sanatorium, he also developed a tuberculous right ankle, tuberculous right petrous temporal bone, cervical glands, and tuberculosis of the sixth right rib posteriorly. Then to top it all, he developed tuberculous meningitis. All of these lesions became inactive after he had received a total of 262 grams of S.M. and 3,296 grams of P.A.S. Finally, a left pneumonectomy was performed to remove the totally destroyed lung (Fig. 12) containing the fistula and, at the same time, the remaining sinus in the chest wall was excised and closed. During this surgery, the patient received an additional 112-day course of P.A.S. and S.M. He is now well with the fistula closed (Fig. 13).

Finally, thoracoplasty has continued a common operation for pulmonary tuberculosis, i.e., the removal of segments of ribs to collapse diseased areas of the lungs to allow them to heal. Recently, plombage in combination with thoracoplasty has become useful to increase the collapse. The commonest plombage materials used are wax and lucite balls. We at Brandon Sanatorium favour the procedure of thoracoplasty with temporary

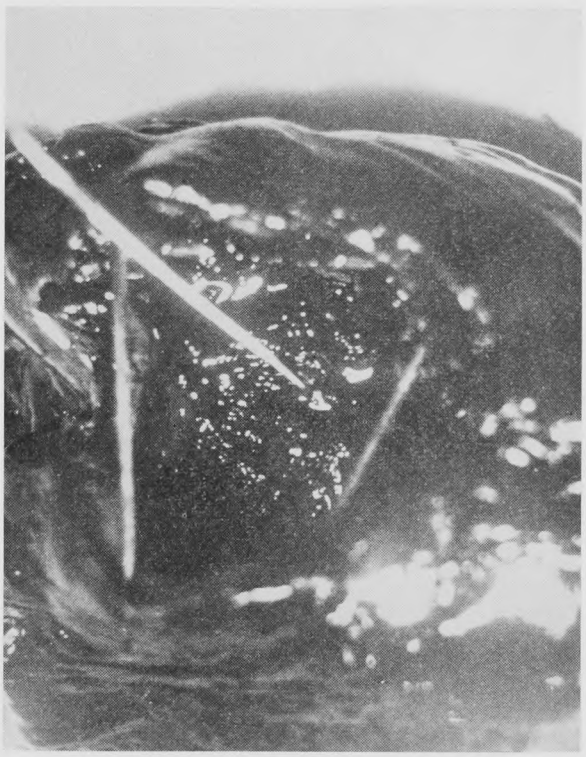


Fig. 9 — Operative Specimen. Same case as Figure 8.

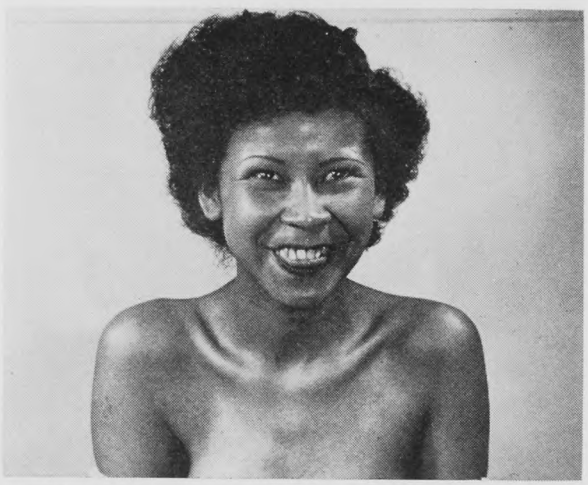


Fig. 10 — Same case as Figure 8. Photograph taken post-operatively.

extra-periosteal lucite plombage. (Fig. 14) The ribs are stripped of periosteum but the bared ribs are left intact. (Fig. 15) Lucite balls are then inserted between the ribs on the outside and the underlying intercostal muscles and periosteal rib beds.

New ribs are produced from the periosteum beneath the balls. After three months, the old ribs and balls are removed (Fig 16).

This method has the following advantages over the conventional multi-stage thoracoplasty: Better and more selective collapse with resection of fewer ribs and, therefore, conservation of more functional lung tissue. Less post-operative deformity and a higher incidence of sputum conversion. Comparing our own results of a small series of 27 cases having this procedure, with 27 having conventional multi-stage thoracoplasty, 74% are negaitive to gastric culture in the lucite series as compared with 62% in the other, and 89% in the lucite series are negative to concentrates or culture as compared with 66% in the other series.

With the development of these new wonder drugs, one may be tempted to try treating patients at home but, from the detailed treatment presented, one should realize that the treatment of tuberculosis should be carried out in Sanatoria where there are the experience, knowledge, and facilities to handle these cases. Tuberculosis is a generalized disease, though it may manifest itself in one or other organ or tissue in the body, so that rest remains the primary treatment factor. At the proper time, after sufficient chemotherapy and rest, and after the acute phase has passed, excisional surgery is becoming indicated more and more often to remove from the lung and elsewhere the foci that contain viable bacilli and remain dangerous to the patient.

To treat at home people with positive sputum would be a definite danger to those in contact with them. Furthermore, these drugs will render a patient abacillary while he is on the drug, but that does not mean he will remain negative. However, in spite of extensive surveys, etc., the diagnosis of tuberculosis still depends primarily on the family doctor. It is a curious fact that generally the well attend the Surveys, Travelling and Stationary Clinics but the ill stay at home, so it is wise to urge all patients to have regular chest X-rays taken.

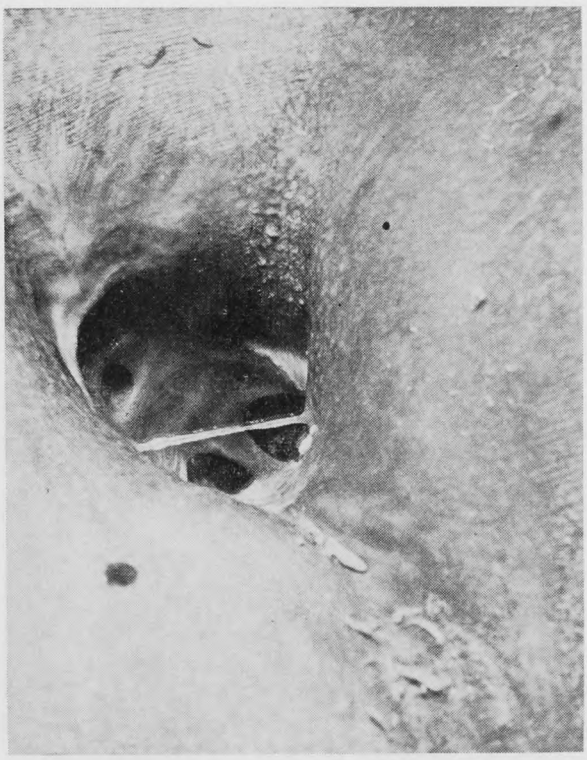


Fig. 11 — Bronchopleural-cutaneous Fistula.

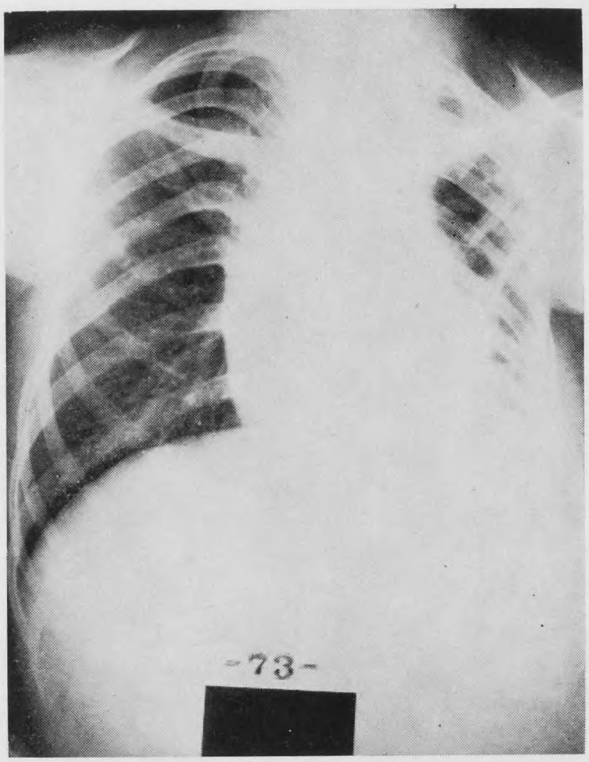


Fig. 12 — Same case as Figure 11. Pre-operative Chest Film.

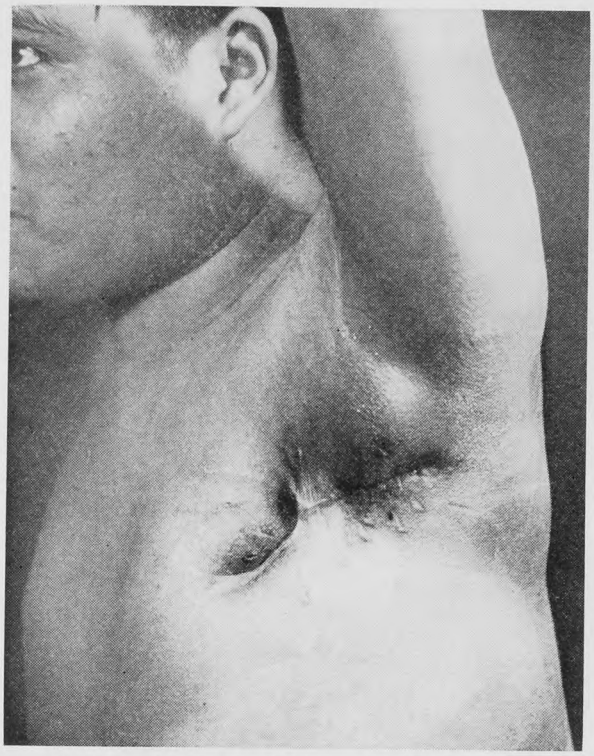


Fig. 13 — Same case as Figure 11. Final Result.

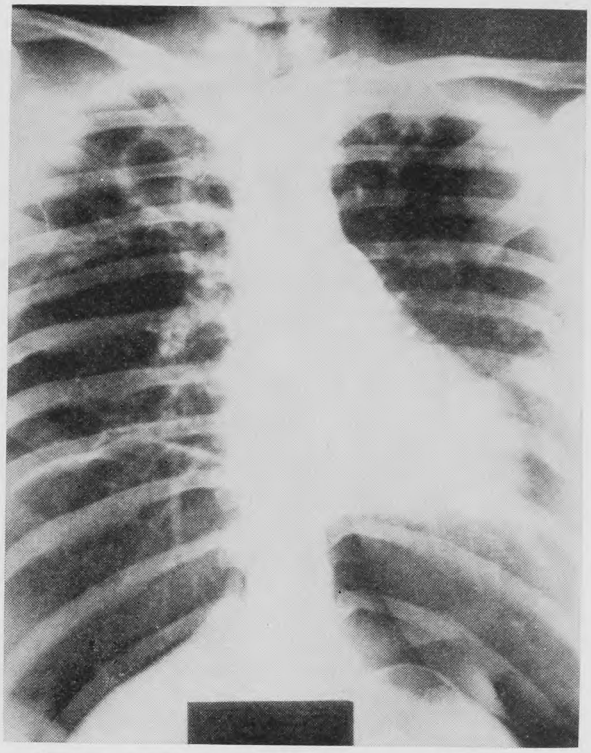


Fig. 14 — A Pre-thoracoplasty Chest X-ray. Bilateral Apical Disease with Cavitation.

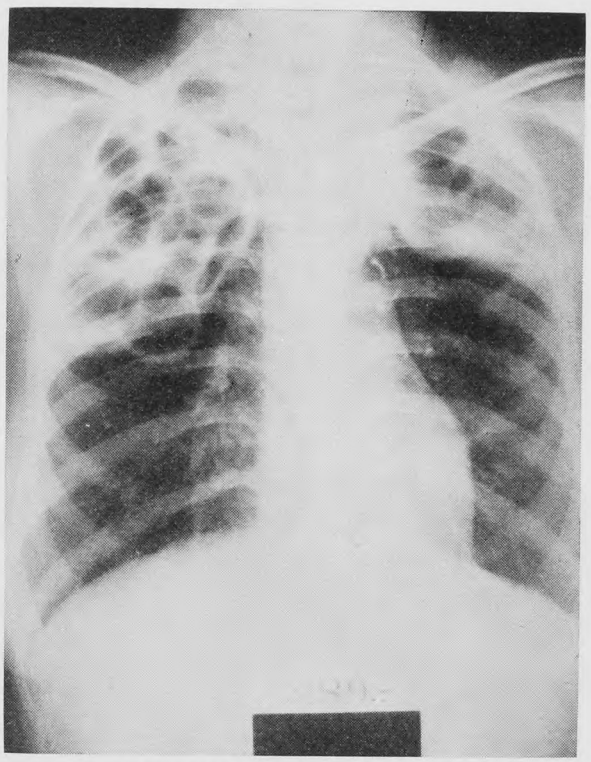


Fig. 15 — Same case as Figure 14. Lucite Balls Placed Extraperiosteally.

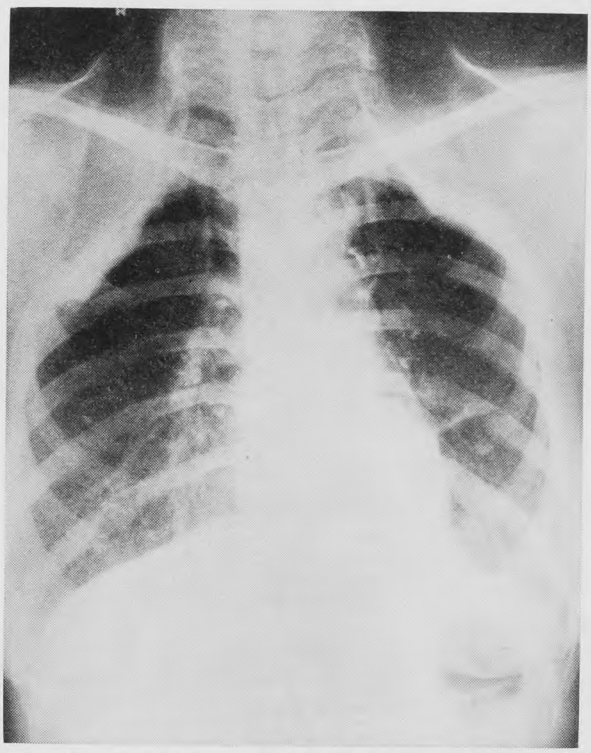
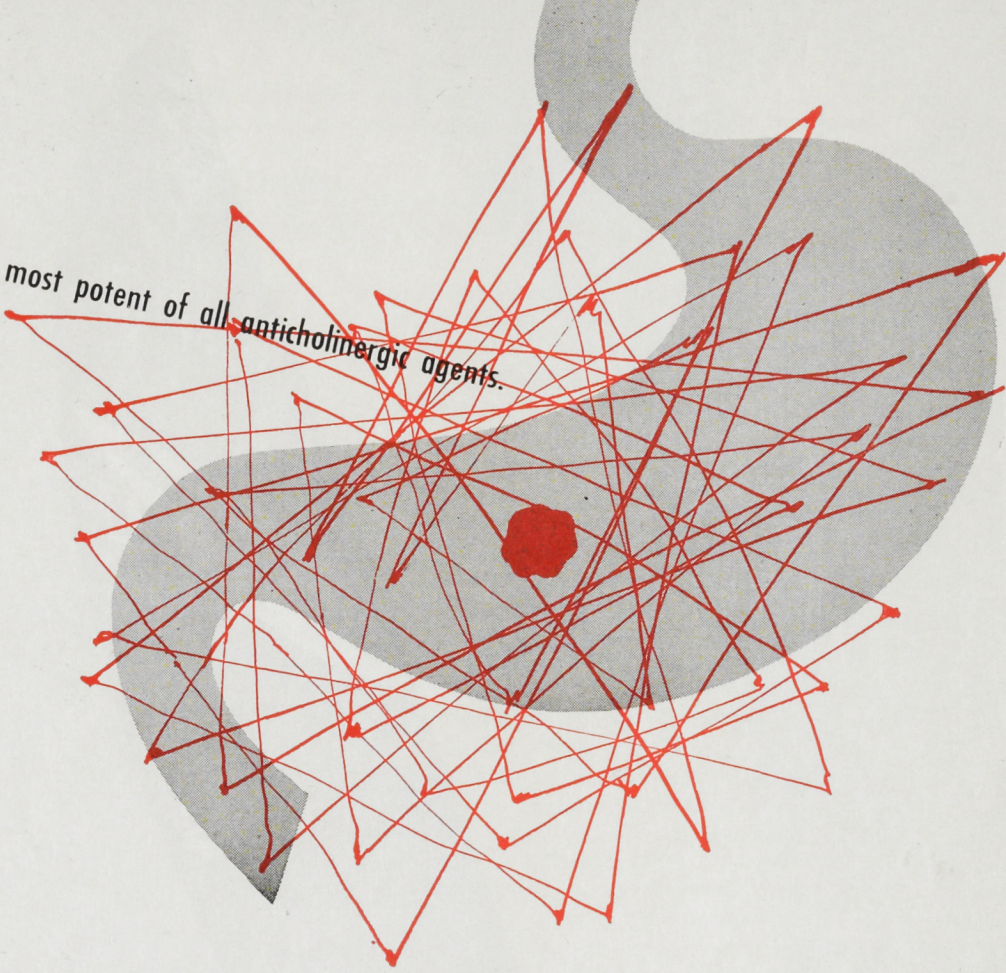


Fig. 16 — Same case as Figure 14. Final Result. Bilateral Apical Thoracoplasty.

Antrenyl

Mg. per mg. one of the most potent of all anticholinergic agents.



Antrenyl is a new high potency anticholinergic agent indicated in the management of peptic ulcer and spasm of the gastro-intestinal tract. *Antrenyl* is highly effective in reducing gastric secretion and gastro-intestinal motility.

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ISSUED:

Tablets, scored, of 5 mg. Syrup containing 5 mg. per 4 c.c. (approximately one teaspoonful) or 20 mg. per teaspoonful.

Vials of 10 c.c., each c.c. containing 2 mg.

For your next ulcer patient prescribe

Antrenyl Ciba

to supplement the traditional regimen of rest, sedation, antacids and diet.

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PYRIBENZAMINE control of seasonal allergic symptoms provides continuous 24-hour relief thus ensuring the patient undisturbed rest at night. The double duration of Pyribenzamine relief is attained by administering one Delayed Action Tablet together with one uncoated Tablet after breakfast and dinner. Release of the Pyribenzamine from the specially coated Delayed Action Tablet is postponed until the effects of the uncoated Tablet are beginning to wear off.

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Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

Exit the Basic Sciences Act

In the dying minutes of a dying session the local Legislature gave the coup de grace to the Basic Sciences Act. Most members of our profession look upon this as a backward step. The Association had so little notice of what was afoot that the knife was whetted and poised before our representatives got on the scene and they were just in time to be in at the death.

Actually, however, it isn't as bad as it sounds. The chiros, the osteos and the naturos have all come under the governance of their respective Acts by virtue of which they can, and undoubtedly will exclude prospective competitors. The "irregular" population is therefore likely to decline rather than increase. There was always the chance—a very slight one to be sure—that a cultist might romp through the basic science examination in which case his legitimate exclusion might have been difficult. Now, with no B.S.A. to help the one or embarrass the others,we may be sure that the voice of the quack will be no louder than before.

Nor is it a matter of great concern in the case of immigrant doctors. The University remains the body to satisfy, and graduates with proper credentials will find admission no more easy or difficult than it has always been.

There is, however, a problem still in the matter of "D.P.s." Not a few of these unfortunate persons lost their documents when they saved their lives. It is no easy task to acquire again those facts which most established practitioners will frankly admit they have long since forgotten. If the University is not quite satisfied with the credentials submitted by such a doctor it may require him to take examinations on these subjects. If proof of competence could be established in some other way the absence of a basic science examination would be no loss.

They, also, are our colleagues though their backgrounds and experiences are so different. Some have faced—and seen—death in guises unfamiliar to us. One told me that, having been taken captive, he was sentenced to be shot on the following day when his captors discovered his profession and, having need of doctors in the camp, reprieved him at literally the eleventh hour.

Such experiences are shattering and, with them in mind, it is not easy to renew old familiarities with anatomical relations or biochemical formulae; especially when to the usual difficulties of learning are added the further embarrassments of a new language, a strange people, the pressure of indigency and the uncertainty of the future. Perhaps there are better ways of proving that a man is knowledgeable and safe.

A Threatened Invasion

There is, however, another point which demands attention. We started off with quackery quite illegal. Then came the acceptance of it in the form of Acts of the Legislature. Now the barrier of the Basic Science Act has been removed. Injured workmen for some time have had the privilege of going directly to any kind of therapist and having their attention paid for out of public funds. The door, once only ajar is opening ever more widely. The next step will be admission to hospital privileges. And don't think that such will not be sought and ultimately gained.

At the moment there is a dearth of hospital beds. I am satisfied that the lack is not wholly genuine. In every hospital there are patients who shouldn't be in at all and others who could have been out days ago. These, taken together, make unavailable for those who really need them a considerable number of these too-few beds.

I cannot forget that for three weeks (during the flood) a city of a quarter million people got along splendidly with practically no hospital accommodation. During those weeks only the really ill sought or got attention, and doctors found (to the amazement of some) that patients could actually get well without the benefit of complicated tests and in the environment of their own homes.

I can recall, also, the time when hospitals were using even the corridors as wards so great was the demand for beds. And, a few years later, I saw those same hospitals close ward after ward because times were bad and patients were lacking.

When all the beds now planned are finally available there will be thousands of them and, inasmuch as history is likely to keep up its practice of repeating itself, it is conceivable that there will again be a plethora of beds. In which case hospitals are not likely to offer serious objections to chiros, etc., who may want to treat patients on the wards.

But even if these "bad" days do not return there will be a demand on the part of the public to get their "treatments" or "adjustments" in hospital. And if the authorities do not frown on the practice—nay, will even pay for it—when conducted in an office or at a home, it is unlikely that they will frown upon it when done in a hospital.

There are many cities in the United States where osteopaths and chiropractors have access to

hospitals and I have no doubt that the time will come when the same will happen here.

"I Do Not Like You, Dr. Fell"

Experience in the past has shown that governments are not greatly interested in our concerns. It is the will of the people, not the wishes of our profession that direct their action. Which, after all, is reasonable because they represent the people and not a group. But no lay body is competent to pass an authoritative opinion on matters of health. The age-long preference for a witch or mountebank before a learned physician is as strong today as ever. Hundreds of people are convinced that they owe their comfort, or even their lives, to irregular practitioners. Hundreds are honestly convinced that "the regulars" are far too free with their knives, far too greedy in the matter of fees, far too narrow in their attitude towards any form of practice other than their own.

The fact is that the "regulars," as a body, are thoroughly disliked and, by comparison, the irregulars are angels of light who bear healing on their wings.

Education — Two Ways

What then? What rests? Can we remedy things by a programme of education? If so, it must be a two-fold programme. First and, I believe, most important, we should absorb into our own practice the nucleus of good in irregular practice. Many, if not most, irregulars are honest people who believe their creed as sincerely as the Mohammedan believes his. They are confirmed in their belief by the results which at times they obtain. The most honest among them realize their limitations, but all of them are certain that, within these limitations, they have much to offer. And if they had nothing to offer they would long since have gone out of business on any but the smallest scale. We can beat them only with their own weapons. Disarm them and they will be safe.

The education of the public is quite another thing. The tree of the knowledge of (medical) good and evil has been practically stripped of its fruit. There is scarcely a lay periodical of any size that does not have at least one medical article in every issue.

Patients no longer come humbly to an oracle as once was the custom. Now they visit their doctor with a ready-made diagnosis (which they will prove out of one lay magazine) and with suggestions as to the proper treatment (which they will prove out of another magazine). Indeed, it may go so far as to have a patient say "I don't really need to see you but I can't get the remedy I need without a prescription. I came in for that." It is the physician who suffers most in this way because so far no lay magazine has published instructions on "How to Take Out Your Own Appendix"; or, "How You Can Adjust Your Own Fourth Dorsal Vertebra."

Telling Our Story

I wonder how many people realize that if it had not been for sympathetic doctors there would be no M.S.S.? How many are aware of the efforts being made by the general practitioners to increase their effectiveness? How many realize that none are more anxious than the doctors themselves to stamp out dishonest practices, and realize, also that no one with a grievance need go without redress?

The overcoming of a preference for the irregulars is of less importance than the overcoming of a prejudice against ourselves. Unfortunately there is no way of advertising our competence or our virtues as if we were a soap. Over the centuries things have not changed one whit. "The lawyer is judged by the virtue of his pleading and not by the issue of the cause. The master of the ship is judged by his directing the course aright and not by the fortune of the voyage. But the physician . . . is judged most by the event; which is ever as it is taken: for who can tell, if a patient die or recover, whether it be art or accident?"

It is difficult to say how much the people should know, or be told, about their minds and their bodies, about their health and their sicknesses. It would be so much better if they would conduct themselves like, as it were, devout communicants, accepting assurance and obeying instruction without the meddlesome interference of their own assumptions and conclusions.

But the appetite for medical articles seems to grow with what it feeds on. "Of all pursuits the pursuit of health is the most unhealthy." People are indeed in a sorry state when they talk of their kidneys with precision and of their livers with regret; when phenobarbital is a household word and medical advances form tea-time topics.

Somehow or other we have got to govern this flow of information and direct this current of thought. If the people must be educated let the instruction come from ourselves and through official channels. And let the education be directed towards the positive aim of improving our relations with the public rather than towards the negative one of condemnation of other forms of practice.

Watch Dogs

The speed with which the Basic Sciences Act was killed is symptomatic of how quickly and with what independence governing bodies can move. Was this a bolt from the blue? Was there no hand writing on the wall? Did the coming event fail to cast its shadow? I do not know, but all these are unlikely. The fact is that the profession is woefully ignorant of what the politicians are up to. We know that they talk about our services as if these were a prize that they are prepared to give to their voters. But what are the words they use, and who use these words?

I believe that we should know each month what was said and done about us in Parliament and in the local Legislature. I have suggested that in the Canadian Medical Association Journal there should be a section headed "This Month in Parliament" in which would be given in summary or in extenso, as the circumstances warranted, the statements made about ourselves and our practice.

Less is said locally but here also our interests should somehow be safeguarded. We should know before hand what is being contemplated concerning us. Perhaps at the coming election our Executive should run for office!

Letters to the Editor

Dear Editor:

The other day a young woman who is one of a large group of potential M.M.S. members entered my office to ask one question. Her question was, "If I join the M.M.S. will I receive the same consideration as I do now as a paying private patient?" Frankly I was puzzled. Her friends had told her she would not.

On pondering the question, I believe I see her reasoning. She and her friends give a dollar's value in work, for one dollar. She therefore reasons she cannot expect a dollar in medical care for eighty cents.

I inquired of my plumber how he would react to eighty cents on the dollar. He replied "I would leave you a leaky tap." My lawyer advised me his advice would not be too well considered.

And we, mere doctors, are presumed to be super humans. Will I ask that midnight caller "Are you on M.M.S.?" and then dash across this city for four dollars less 5% penalty plus multitudinous damns!! at the icy streets.

Isn't it now time in this year of our Lord 1953 to receive one hundred cents on the dollar less administrative costs?

Then too, can we look forward to a time when our accumulative contribution to M.M.S. will be repaid? Would it not be a nice idea for M.M.S. when that happy time arrives as it surely will under our present excellent management, to contribute said funds to a Manitoba Benevolent Fund? This, I am sure, would meet with the blessings of the profession.

Yours truly,
J. F. Edward, M.D.

* * *

Dear Sir:

Dr. J. F. Edward has been kind enough to show me the original copy of his letter to you (above printed). I have been asked by Manitoba Medical Service to comment on it.

Firstly, as to the consideration paid by the doctor to an M.M.S. patient, I think the answer is provided in the terms of the contract signed by the medical members of M.M.S. This is reproduced in the latest M.M.S. booklet and will be found under the heading D—Physician, page D-3, paragraph 1.

Secondly, as to the percentage payment to the medical members being still short of 100 less administration expense, the Board of Trustees of M.M.S. has for many years devoted much study to the means of achieving the logical ideal. Rate increases to subscribers have been made with the hope of effecting this end but inexplicable rises in utilization and patent increases in the fee schedule have combined to postpone the desired result. The recent increase in obstetrical fees alone, on the basis of 1952 figures, accounted for 3.3% of our payments to physicians. Had these increased fees not been authorized, M.M.S. could have increased their payments by 3.3% during the past calendar year. However, M.M.S. is presently engaged on the study of further rate increases to subscribers and it is to be hoped that the average annual percentage payment to medical members will continue to increase. (My first contact with M.M.S. in 1945, Dr. Edward, yielded me a 55% payment based on a fee schedule—considerably lower than the present one.)

The eventual repayment of the "accumulative contribution" referred to is, unfortunately, an impossibility. The deficit in payments to the doctors, has been written off the books of M.M.S. at each annual meeting.

The Board of M.M.S. would welcome the establishment of a Manitoba Benevolent Fund to which it could contribute—say the 5% penalty monies.

Yours truly,
C. E. Corrigan, M.D.,
Treasurer, M.M.S.

Appeal for Funds — Joint Hospital Committee

Dr. P. H. T. Thorlakson, Chairman of the Medical Section of the Joint Hospital Committee, appeared before a recent meeting of the Manitoba Medical Association Executive Committee to enlist support for the appeal for funds being made by the Winnipeg General Hospital and the Children's Hospital. The managers of the campaign expect the medical profession to give leadership in such an undertaking since the construction programme will provide increased facilities, and should raise the standards of medical practice and medical care for the people in this province.

In the discussion it was emphasized that the Association is interested in the development of every hospital in the province, wherever located. The two hospitals on whose behalf the present appeal is being made perform valuable services

for the doctors of the province in regard to graduate and postgraduate education, research, and highly specialized equipment for the diagnosis and treatment of rare cases. They are, in addition, a source of training for nurses who staff other hospitals in the province.

The Executive Committee, by resolution, urged the medical members of the Manitoba Medical Association to adopt an attitude of sympathetic co-operation toward the campaign by personal contribution or active assistance to the campaign committee in their own locality.

W. F. Tisdale.

Brandon and District Medical Association

A meeting of the Brandon and District Medical Association was held at the Nurses' Home, Brandon Hospital for Mental Diseases, on Wednesday, March 25th, 1953. Through the courtesy of the Superintendent, Dr. S. Schultz, dinner was served at 6.30 under the able supervision of the Dietitian, and following the introduction of head table guests, the President, Dr. J. B. Baker, called for each person to be introduced. The thanks of those assembled was expressed by Dr. F. J. E. Purdie.

Scientific Session

Present were: Doctors J. B. Baker, President; R. F. M. Myers, Secretary-Treasurer; J. S. Brown, M. E. Bristow, Chan, R. P. Cromarty, Elizabeth Cziller, W. Czubaty, G. B. Elliott, Kathleen A. Elliott, H. S. Evans, J. A. Findlay, F. Fjelsted, W. Forster, C. L. Hsu, J. M. Matheson, R. O. McDiarmid, H. M. McIntyre, A. H. Povah, F. J. E. Purdie, S. Schultz, V. J. H. Sharpe, E. J. Skafel, E. D. Winchell, Brandon; G. L. Hermitte, Baldur; G. T. McNeill, W. H. Patterson, Carberry; W. J. Sharman, Clanwilliam; M. A. Sirett, Nancy Sirett, Erickson; F. K. Purdie, Griswold; J. E. Hudson, Hamiota; W. K. Hames, Kenton; J. R. Stratton, Killarney; G. J. Creasy, Newdale; G. I. Wortzman, Rivers; N. M. Kester, Wawanesa; J. D. Adamson, M. T. Macfarland, M. B. Perrin, Winnipeg.

At the Scientific Session, which was held in the Classroom, Doctors Stuart Schultz and Magistrate A. W. Stordy discussed the Admission of Patients to Mental Hospital, and Dr. M. B. Perrin, Winnipeg, discussed Tracheotomy in Bulbar Poliomyelitis, illustrating his talk with the slides taken during the recent experience at Municipal Hospitals, Winnipeg.

Dr. J. D. Adamson, Chairman, Medical Advisory Committee of the Canadian Arthritis and Rheumatism Society, discussed the need for improved facilities for treating arthritis and the possibility that a mobile unit might be established if sufficient local support might be obtained.

Doctors Findlay and Hudson discussed matters referred by the Executive Committee, Manitoba Medical Association, including the 86th Annual Meeting of the Canadian Medical Association in June and formation of new district societies.

Dr. Skafel discussed formation of a local medico-legal group.

Following the meeting, members were entertained at the home of Dr. and Mrs. Baker.

The Victorian Order of Nurses

The Hon. Paul Martin, Minister of Health, announced recently that more home nursing was necessary "if we are to avoid over-crowding our hospitals with people who could better be looked after at home."

Home bedside care is available in almost all of Greater Winnipeg now, as Old Kildonan, East and West St. Paul have recently been added to the territory served by the Victorian Order of Nurses. Doctors with patients in these outlying districts are reminded that Victorian Order nurses are ready to carry out their instructions and give complete nursing care on a visit basis.

Visits cost the Victorian Order $2.00 each. In 1952 this full fee was paid for 15% of our visits. For 44% of our visits we received a fee varying from 25c to $1.75 and the remaining 41% were free.

It is because the Victorian Order is a Red Feather agency that the fee for nursing can be scaled to fit the circumstances of the patient. The adjustment, when necessary, is made by the visiting nurse.

Psychiatric Section Meeting

A meeting of the Psychiatric Section of the Manitoba Medical Association was held at Brandon Mental Hospital on Wednesday, May 20th, 1953.

During the Scientific Session Dr. J. Matas spoke on "Psychiatric Reactions of Pregnancy." A lively discussion followed this paper. A report of interesting papers heard at the recent meeting of the American Psychiatric Association in Los Angeles was presented by Drs. J. Burch and J. Lindsay.

Following the meeting Dr. Stuart Schultz and his medical staff entertained the visiting members and guests at a very enjoyable reception and dinner.

Obituary

James Moore Morrow

Jimmy Morrow (he was my friend and so will I call him) died within a few minutes on April 14th in the hospital at Fisher Branch. Not many of the local doctors knew him, or even of him, because his professional life was spent beyond the Province. He graduated in 1919 along with Thorlakson, Boris and Robert Black, Chris Backman, Etsell, Beaton, Ellen Taylor, Dan Nicholson and myself. All these were present at the obsequies. Those others who, with us, had kneeled before the Chancellor to be admitted to our degree lived far away or had ceased to live.

The thoughts of all of us, I imagine, were on the same things as the organ whispered its threnody. The years were cast off and again we saw ourselves in the unfamiliar environment of the college, young strangers making acquaintance with each other and forming friendships. There were incidents in the dissecting room and laboratories, and lecture theatres that sprang to memory. We recalled the night of our initiation and that other occasion when we gathered at midnight to attend the Court of the Owls. I wondered if transgressors of the college laws were still so punished.

From these excursions into the past the throbbing organ recalled us to the present. Perhaps these memories drew us who were left more closely together than we had been since the days of which we thought; and there was a bond, also, in the circumstances under which we were meeting. We thought of those whose bodies had already been committed to the grave and we pondered over their ends and what had led to them.

". . . and at last I spake with my tongue; Lord, let me know mine end, and the number of my days . . ." The cry of Job goes unanswered; yet we, whose work lies with the sick, have each seen the manner of our end. For we all have stood at bedsides where men lay suffering, as we shall suffer; and have seen death come for others in the same manner as it will come for us, though the time of our end is hidden from us.

He died alone, a fate which, in the minds of many, is the unhappiest of all; for most would have loving hands hold theirs when the bond is being sundered. But it does not greatly matter. Those who have been in the jaws of death and have escaped know how little it matters. The eye and ear may still perform their duties but the numbed brain cannot separate the intruder from the one desired, nor can it distinguish the word of encouragement from the sob of anguish.

"Man that is born of a woman hath but a short time to live and is full of misery. He cometh up, and is cut down like a flower. . . . In the midst of life we are in death."

Jimmy had been in retirement for about four years but idleness bored him. Therefore three weeks at Fisher Branch promised to be a pleasant interlude. On the way he developed thrombosis of the retinal vein of one eye but refused to turn back. Two weeks had passed when he had to bring a sick child to a larger hospital. In spite of his blindness he was in good spirits and could not be persuaded to stay.

It is strange how Fate shows daily that it will not be denied. He returned north out of a sense of duty; but an appointment had been made for him, of which he did not know, but which he had to keep, and he returned to keep it.

He knew what the pain meant because this was not his first attack. He lay down upon a bed in a room where he was no stranger but which he had not thought of as the place where he would die. He asked for morphine and was given it. He asked for oxygen and was eased. A friend who had come to see him found him thus and went to telephone his wife. When he came back Jimmy was dead. From start to finish it was but twenty minutes. Death was in a hurry. So may he be when I meet him.

"The days of our age are three score years and ten." But he was only sixty-three, not a great age. And he looked no older. His hair was only greyed and his cheeks had not lost their ruddiness. Apart from the loss of vision in one eye he had retained all his faculties and functions. He had lived a full life and, on the whole, his lines had fallen in pleasant places.

While an undergraduate he spent a year in the Children's Hospital. He loved children and easily won their affection. Indeed, his genuine friendliness was an open sesame to hearts of every age. Later he served in the Winnipeg General Hospital and there he met his first wife.

He went to Yorkton where, in a few years, he gathered a large practice and then moved to Winnipeg. In 1930 he was offered, and accepted, an appointment with the Department of Indian Affairs and was posted at Fort Smith in the Northwest Territories. The Indians had not always been well served by their doctors and they quickly appreciated his kindliness, understanding and skill. They came to look upon him not only as their doctor but also as their guide, philosopher and friend. The Government took notice of this and appointed him stipendiary magistrate. On the occasion of the coronation of our late King he was decorated in recognition of his services.

He was given a position of greater responsibility at Prince Albert and while there his wife died leaving him with three children. Later he remarried and was posted to Vancouver Island where he was at the time of his first heart attack. When

his boys were of an age to enter College he came to Winnipeg with them and saw his older son graduate in medicine last year.

He was of too active a nature to enjoy retirement. He missed his Indians. He missed the mental exercise posed by each diagnostic problem. He missed the comfort that comes from making others comfortable, and the satisfaction that comes from seeing the sick grow well.

As I looked about the crowded chapel I wondered if all these people could have known him; he had neither lived nor practiced long in Winnipeg. But they were all his friends. Some had worked with him, some had been his patients. All had profited by his help and advice. But not all were from the City. Many had come from Yorkton, from Prince Albert, from Edmonton, from the Territories, from British Columbia. Indians were there as well as Whites; many people from many places who had come together to do honour to a dear friend. It was a remarkable tribute to pay to a modest, unassuming man who, without fuss or advertisement, had done his work day by day with little thought for himself and with much for others.

"A good name is more to be desired than great riches." His family must have been very proud when they saw how high his name was held by so many.

J. C. H.

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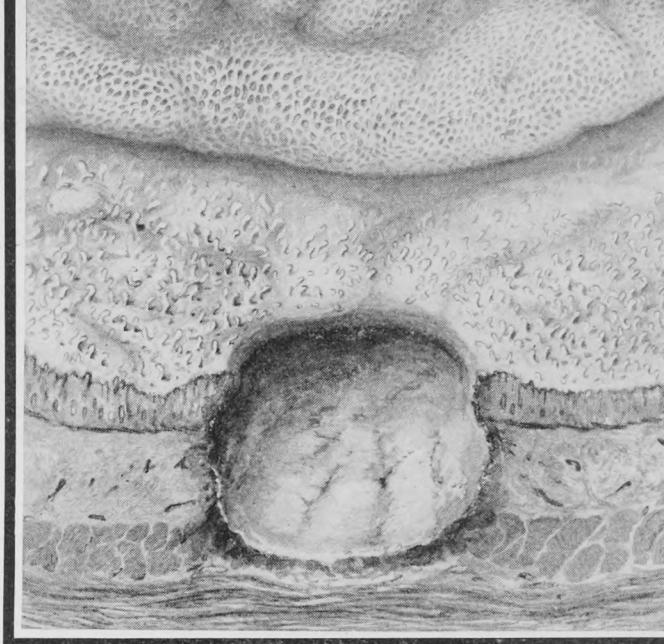

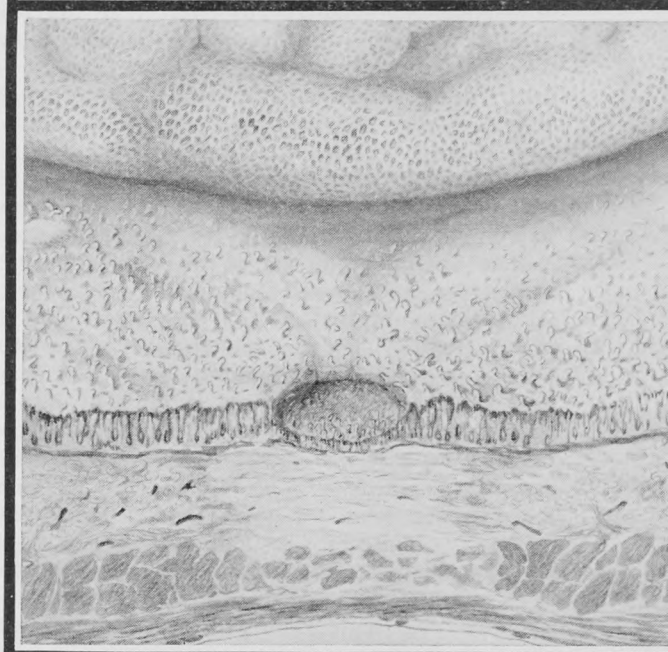

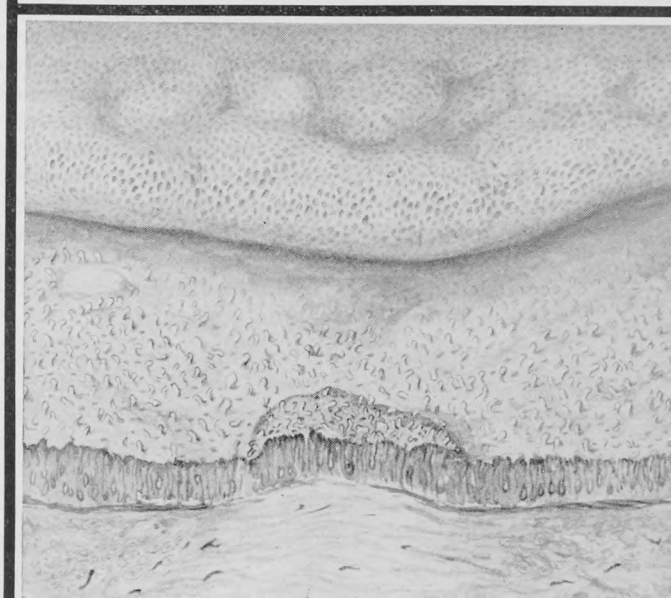

Top—Section through duodenal bulb just distal to pylorus through center of ulcer crater.

Center—Healing ulcer with scar tissue and regeneration of tissue layers.

Bottom—Healed ulcer with restoration of mucosa.

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Winnipeg Medical Society

Reported by R. H. McFarlane

A special meeting of the Society was held in conjunction with the Annual Refresher Course of the Medical College, on 17th April, in Theatre A, Broadway Buildings. The speaker of the evening, Dr. Hugh Morgan, Professor of Medicine, Vanderbilt University, was introduced by Dean Lennox Bell. The topic under discussion was:

The Use of Antibiotics

In dealing with the subject, Dr. Morgan started with an account of the use of the sulphonamides. He mentioned particularly the value of sulphamerazine and sulphadiazine in meningococcal infections and bacilliary dysentery, of the relatively non-absorbable sulphaguanidine and sulphathalidine in bowel infections; and the use of gantrisin in urinary tract infections. Before going on with the use of penicillin, Dr. Morgan discussed the changes wrought in medical practice since the discovery of these chemotherapeutic agents and antibiotics. This was both interesting and instructive, especially to those in the audience whose medical memories do not reach back to the pre-sulpha era. Speaking of penicillin, Dr. Morgan left little doubt that he felt this still to be the most versatile, economic and useful of the antibiotics, particularly with reference to the Gram-positive groups of organisms. He went into its use by various routes. He was enthusiastic about its oral use but was unimpressed with penicillin aerosol. Erythromycin, he felt, had less to recommend it but noted its similar bacterial spectrum and its availability for penicillin-sensitive patients. He also noted its efficacy in staphylococcal infections and inefficacy in syphilis. On the subject of streptomycin, Dr. Morgan was no less enthusiastic about its use against Gram-negative organisms and about its use in tuberculosis. It was particularly interesting to hear his rather glowing account of its use in tuberculosis and some of his remarks about the development of bacterial resistance. About the use of the aureomycin, chloramphenicol, terramycin trio of "broad-spectrum" antibiotics, Dr. Morgan was less enthusiastic, but did mention their special value in virus pneumonia (a disease he himself scarcely recognized), rickettsial diseases, amoebic dysentery, typhoid, brucellosis and granuloma inguinale.

The interest and enquiring frame of mind of the audience was attested by the fact that the original talk lasted one hour, and the discussion and question period lasted just a few minutes longer than the hour.

The regular meeting of the Society was held on Friday, 24th April, 1953.

Blood Transfusions

Dr. G. E. Large spoke briefly about problems arising from the rather heavy use of blood for transfusions and mentioned that over 2,000 bottles of blood had been issued where possibly one-half of this amount was, in fact, really necessary. He stressed the need for proper indications for use of blood and mentioned some of the possible risks. He also pointed out that about 1/3 of the bottles after being suitably cross-matched, were returned and showed the amount of wasted technical labor involved and further mentioned that 70% of routine cross-matching requests were made after 5 p.m. and that 50-75% were also labelled "stat." He ended with a plea for better co-operation with the Red Cross in this regard and pointed out that some restrictions might otherwise have to be employed.

Arthritis

Dr. J. D. Adamson also spoke briefly on behalf of the Canadian Arthritis and Rheumatism Society. Dr. Adamson is one of the prime movers in this organization and is Vice-President and Chairman of the Medical Advisory Committee of the Society's Manitoba Division. He gave a progress report of the activities carried out here and projected plans for the next year. He ended with a plea for generosity on the part of the medical profession in regard to the coming financial campaign of the Canadian Arthritis and Rheumatism Society. Your reporter also being on the board of this Society is also most anxious for a generous response.

The Placenta and Congenital Disease

The main speaker of the evening, W. J. Hamilton, M.D., D. Sc., F.R.S.E., Professor of Anatomy in the University of London, Charing Cross Hospital Medical School, was introduced by Professor I. M. Thompson. Professor Hamilton's topic was "The Placenta and Congenital Disease."

Professor Hamilton noted first the wide range of normal developmental variation and pointed out that variations from the normal might occur either in structure or in function (metabolism). He felt the abnormal embryo was not to be considered separately from its environment, which is chiefly the placenta. He pointed out that some abnormalities are genetically determined but these were not under discussion at the moment. He went on to discuss such factors as the protective functions of the uterus and membranes, the incomplete impermeability of the placenta to noxious agents, the interplay of inheritance and environment in the production of abnormality, and the time in the course of fetal development at which the noxious agent acts, pointing out that the earlier

any particular factor acts, the more severe will be the resultant abnormality.

One of the most important disorders which affects the course of foetal development is rubella. He mentioned a 30% to 50% chance of foetal abnormality occurring and said that the time at which the infection occurred could be correlated with the type of abnormality found. This apparently depends on what organs are actively developing at the particular time. Thus if infection occurs about the sixth week of pregnancy the eyes are likely to be affected but if later deafness may result. The exact mechanism is not understood.

The paper was discussed by Drs. Bruce Chown, Brian D. Best and Prof. Thompson.

A Visit to Moscow

A Report (after a fashion) of an Address by Dr. L. S. McMorris

One of my principal difficulties as an editor is obtaining the fulfillment of promises made to me by those who undertake to supply typescripts. One of these offenders is Dr. McMorris who recently gave a talk on "Medicine in Russia," before the Winnipeg Medical Society. It is possible (all things are possible) that he may yet supply me with his paper because the following is only that part of what he said which clings to my memory; but with this you must needs rest contented until such time as the spirit moves Dr. McMorris to fulfill his engagement.

Dr. McMorris gained entry to Russia as medical attendant to the Embassy of Her Britannic Majesty, and, assisted by an American medical officer, he had the responsibility of caring for the health of the five hundred or so (I think that is the number) people who made up the Foreign Colony in Moscow; there being few, if any, foreigners unattached to embassies.

His arrival on Russian soil was not unpleasant, for the Intourist officers who met him were young ladies. Now, Dr. McMorris has a nice taste in the matter of pulchritude and he regarded the specimens before him as female rather than feminine and definitely second class. Still, it was a promise that he would not at all times be surrounded by bearded moujicks. I gathered, however, that during his stay in Russia he found the ladies little to his liking. He did not say how he appealed to them.

The embassy sick were seen and examined in a polyclinic staffed by Russians of moderate attainments. The place was not modern in plan or equipment. The laboratory service was, at times, adequate but the X-ray equipment dated back to the time of Karl Marx, more recent apparatus no doubt being condemned as the handiwork of Trotsky deviationists or exponents of imperialism or the like.

It would appear that once a diagnosis had been made the treatment lay largely in Russian hands. Certainly this was the case when patients were sent to hospital. Dr. McMorris assumed that he would have access to hospitals especially when his own patients were concerned. But this was not so. I gather, (I do hope my gatherings are correct), that he was admitted just beyond the front door, robed in a gown, permitted to peer into the hall and then disrobed. On one or perhaps two occasions he was allowed to go farther and what he saw impressed him unfavourably. Moreover he was watched as carefully as if the crown jewels were loose about him.

In fact the whole atmosphere was thick with suspicion. He quickly learned that from the moment he entered Russia he had become a member of the order caudata—everywhere he went he was "tailed." It became his habit to spot his "tail" as soon as he left his embassy or his lodgings. The Russians appear to be exceedingly naive. They are child-like in their suspicion and child-like in their shadowing. Dr. McMorris, having what the Scots would call a "pawky" humour, took advantage of this tailing business and, when an afternoon threatened to be dull he, with some colleague, would play hide-and-seek a la Rousse. Thus they would enter and leave trams or buses, dodge here and there, double on their tracks and so on in their game of "shake the tail." It mattered little to them whether or not they succeeded. It gave them a pleasant outing and served to whet their appetites for caviar and vodka which, according to Dr. McMorris, is a pleasing combination once you have acquired the taste for it.

The mention of caviar brings to my mind a story which I heard from Dr. Markovits which is assurance of its accuracy. It seems that a Russian (whom we shall call Ivan), and a Jew (whom we shall call Mo), were in conversation when Ivan asked how it was that the finest houses in the best suburbs belonged to Jews. Mo answered "Maybe we are brighter than you." "How," asked Ivan, "did this come about?" Said Mo "Maybe it's because we eat—." (giving the Hebrew name for fish-eggs). "Can I get some of this what-ever-you-call-it?" asked Ivan. "Sure," answered Mo, "I'll get some for you." "How much does it cost?" "So many roubles a pound." "Then get me a pound." In process of time the transaction was completed. Ivan opened the parcel, looked at, smelt and ate of its contents. "Why," he said, "this is just—, (giving the Russian name for fish-eggs), I can buy this anywhere for so many fewer roubles a pound." "See," answered Mo, "you're getting brighter already!"

A member of the Australian embassy (or legation) received a letter from a wealthy Australian

concerning retinitis pigmentosa. He had heard that a Russian doctor had found a cure for this ailment and he was personally interested. Could it be arranged for him to see this surgeon? The surgeon in question lived in Odessa. The Australian asked McMorris to look into the matter, which he did. As usual a thousand difficulties and delays resulted. He could find out little by any means of communication so finally he set off with a friend — a gentleman friend — for Odessa. He wanted to see the place anyway.

I forget what stratagem he employed to find accommodation but he was quite unsuccessful in his arrangements to see the genius who, incidentally, lived ten miles away. The usual promises were followed by the usual delays. (It has just occurred to me that Dr. McMorris may have learned something in the matter of promises since he went to Russia).

Disappointed in many ways our friends determined to try to see the surgeon sans authority. At first they went by taxi but, some miles from their destination, were turned back. Next time they tried going by bus but were again sent back. Then they started out on foot—with, of course, their tails—and again they were stopped. Finally they gave it up as a bad job and returned to Moscow.

Somewhere he found a reference to the treatment in question and had it translated for him. It seems that the great secret was the grafting into the patient of a piece of skin from a corpse. When I heard this I was astounded by the ignorance of the Russians. Why, everyone even six centuries ago, knew that it wasn't the skin of a corpse that was really magical but the moss that grew on the skull of a hanged criminal who had rotted in his chains. How backward can a people be!

It would appear that, in Russia, everything has to be done the hard way. The usual departure time for airplanes is 3 a.m. This, being the most awkward hour of the twenty-four, is naturally the hour chosen. As permits, etc. are never ready until a matter of minutes before the plane leaves, the procedure is guaranteed to keep one on the go. Getting a permit of any sort is, apparently, a matter of no little difficulty. Postponement is the rule.

All matters concerning travel are handled by the Intourist organization. Through it reservations are arranged (but not always made). To book accommodation is one thing. To get it, quite another. But to a person of Dr. McMorris' ingenuity such failures added spice to life in Russia. He found that if he booked rooms at a hotel they were almost certain to be unavailable when he got there; so he just arrived without reservations, said that they had been made and was naturally believed, the clerks being fully aware of Intourist deficiencies. After listening to him I haven't the slightest doubt that the cold war was made definitely warmer by the antics of Dr. McMorris and those whom he incited to like behaviour.

Moscow, he said, was a city of shacks and tenements. The ordinary facilities which to us have become commonplace are luxuries to the Moscovites. And yet, amid this squalor, there are magnificent buildings. He spoke of the vast theatre with its immense stage which juts into the auditorium and upon which troops of players and even of horses appear.

One hospital in particular is outstanding, at least for size. It is named after a prominent surgeon who won fame and fortune by his success in penoplasty. This suggests, although Dr. McMorris did not say so, that the Russians are not completely godless but have revived a sort of phallic worship that has a bloody priest they semi-deify.

Now, what more he said has dropped from my memory. He spoke in such a fashion as would have won approval from the American Witch-hunters. None of us went out to lay plans for a visit to Russia. If the best of the visit is the acquiring of a taste for caviar and vodka the same thing can be done here, at greater expense, to be sure, but also in greater comfort and safety.

This is a poor substitute for Dr. McMorris' talk being both incomplete and, I fear, inaccurate. Perhaps these faults may stir my faithless promiser to push aside his vodka and caviar and to behave less like a Russian.

J. C. H.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1952 Apr. 19 to May 16,'53	1952 Mar. 22 to Apr. 18,'53	1951 Apr. 20 to May 17,'52	1951 Mar. 23 to Apr. 19,'52	Total Jan. 1 to May 16,'53	Total Jan. 1 to May 17,'52
Anterior Poliomyelitis	3	1	0	0	26	0
Chickenpox	86	63	91	81	589	552
Diphtheria	0	0	0	0	3	1
Diarrhoea and Enteritis, under 1 yr.	6	5	11	16	33	47
Diphtheria Carriers	0	0	0	0	0	0
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	0	0	1	5	3	11
Erysipelas	4	5	2	0	18	7
Encephalitis	0	0	1	0	0	1
Influenza	34	57	31	29	140	80
Measles	191	236	184	127	2007	623
Measles—German	5	1	3	1	24	9
Meningococcal Meningitis	3	2	1	2	16	7
Mumps	78	78	91	143	579	720
Ophthalmia Neonatorum	0	0	1	0	0	1
Puerperal Fever	0	0	0	0	0	1
Scarlet Fever	41	27	79	74	203	358
Septic Sore Throat	11	3	4	16	19	41
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	1
Trachoma	0	0	0	0	0	0
Tuberculosis	147	61	89	62	336	276
Typhoid Fever	0	0	0	0	0	0
Typhoid Paratyphoid	0	0	0	0	0	0
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	0	1	1	0	1	1
Whooping Cough	20	9	11	22	58	151
Gonorrhoea	83	60	107	101	409	481
Syphilis	3	9	10	12	32	48
Infectious Jaundice	23	40	2	4	137	16
Tularemia	0	0	0	0	1	0

Four-week Period April 19th to May 16th, 1953

DISEASES (White Cases Only) *Approximate population.	*798,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
Anterior Poliomyelitis	3	1	3	12
Chickenpox	86	164	1410	....
Diarrhoea and Enteritis, under 1 yr.	6	27	....	....
Diphtheria	....	....	1	2
Diphtheria Carriers	....	....	....	....
Dysentery—Amoebic	....	....	....	....
Dysentery—Bacillary	....	....	17	12
Encephalitis Epidemica	....	....	....	1
Erysipelas	4	2	....	....
Influenza	34	2	212	22
Jaundice Infectious	23	17	56	81
Measles	191	790	2037	856
German Measles	5	64	484	....
Meningitis Meningococcus	3	4	6	9
Mumps	78	79	1259	....
Ophthal. Neonat.	....	....	....	....
Puerperal Fever	....	....	....	....
Scarlet Fever	41	66	219	145
Septic Sore Throat	11	10	3	57
Smallpox	....	....	....	....
Tetanus	....	....	....	....
Trachoma	....	....	....	....
Tuberculosis	147	27	85	207
Tularemia	....	....	....	....
Typhoid Fever	....	1	2	2
Typh. Para.-Typhoid	....	....	....	....
Typhoid Carriers	....	1	....	....
Undulant Fever	....	....	2	14
Whooping Cough	20	51	46	9
Gonorrhoea	83	....	136	....
Syphilis	9	....	52	....

†This is the total for a three-week period only as we did not receive the reports in time to make up this report.

DEATHS FROM REPORTABLE DISEASES

For the Month of April, 1953

Urban—Cancer, 62; Influenza, 1; Pneumonia, Lobar, 1; Pneumonia (other forms), 13; Pneumonia of newborn, 3; Poliomyelitis, 1; Tuberculosis, 5; Diarrhoea and Enteritis, 2; Infectious Hepatitis, 1. Other deaths under 1 year, 25. Other deaths over 1 year, 233. Stillbirths, 16. Total, 274.

Rural—Cancer, 38; Influenza, 6; Measles, 1; Pneumonia, Lobar, 4; Pneumonia (other forms), 10; Pneumonia of newborn, 2; Tuberculosis, 4; Chickenpox, 1; Diarrhoea and Enteritis, 2; Meningococcal infections, 1. Other deaths under 1 year, 18. Other deaths over 1 year, 194. Stillbirths, 15. Total, 227.

Indians—Influenza, 1; Pneumonia (other forms), 2. Other deaths under 1 year, 4. Other deaths over 1 year, 3. Stillbirths, 2. Total, 9.

•

Poliomyelitis has had a high incidence for the first few months of 1953. It is hoped that these cases are the last few embers of the 1952 epidemic which finally reached a total of 841 reported cases and caused 30 deaths.

Meningococcal infection has been slightly more prevalent than usual.

Tuberculosis shows a slight increase so far this year—probably due to large surveys undertaken already in 1953.

Venereal Diseases show a definite decline in 1953.

Jaundice Infectious (hepatitis) is common and widespread throughout the Province.

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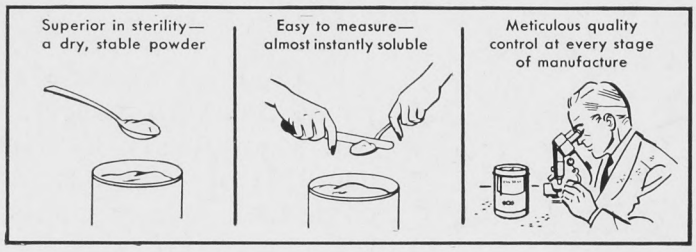
Dextri-Maltose No. 1, for routine infant feeding, is the basic Dextri-Maltose product. Dextri-Maltose No. 2, especially for premature infants, contains 50 mg. ascorbic acid per ounce. Dextri-Maltose No. 3, to aid in counteracting constipation, contains 3% potassium bicarbonate.

A formula supplying 20 calories per fluid ounce is easily prepared with 1 part evaporated milk and 2 parts water, plus 1 tablespoon Dextri-Maltose to each 5 ounces



Dextri-Maltose

MEAD

MEAD JOHNSON & CO. OF CANADA, LTD.
Belleville, Ontario

Local Representative: George Moore, 494 Niagara St., Winnipeg, Man.